Portfolio of Doctorate in Health Psychology: A window on the workings of a hospital-based trainee health psychologist.

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Contents

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Abstract

This portfolio details work completed for the purpose of fulfilling the five competencies that form the Professional Doctorate in Health Psychology.

Professional practice. At the start of training, the trainee worked as a Trainee Health Psychologist within one NHS trust. The professional competence was fulfilled throughout training by working in accordance with the BPS/HCPC guidelines and codes of conduct. A copy of the trainee's log of training, signed by the trainee's supervisor, is included in this portfolio alongside the reflective commentary.

Research: A systematic review was undertaken, exploring the potential of psychological interventions to impact self-management in adults with type 2 diabetes(T2DM). Research paper one, a research paper was completed outlining the potential barriers to behaviour change implementation in a specialist diabetes team. Research paper two is a case study exploring the use of hypnotherapy in addressing needle phobia in type II diabetes.

Behaviour Change Intervention (BCI): the case studies submitted for the fulfilment of this competence involved taking an in-depth look at a one-to-one session with an individual with diabetes and issues around medication adherence, as well as a group intervention in pain management.

Consultancy: External links were made for the purpose of consultancy which sought to assess and evaluate the potential benefit that engaging in crafts could provide for general health and wellbeing in the local community. This is an area of personal interest. The resulting case study explored the potential well-being effects of engaging in crafting.

Teaching and Training; Additionally, external links were developed with an external agency for the purpose of consultancy. A training series was developed 'Psycho-neuro-immunology in Health Psychology' to NHS health staff for the teaching and training competence.

Reflective commentary: The portfolio ends with an in-depth reflective account of experience of training, exploring the highs and lows of working in a hospital- based

health psychology department while pursuing the Professional Doctorate in Health Psychology.

Declaration

No portion of the work referred to in this thesis has been submitted in support of an application for another degree or qualification of this or any other university or other institute of learning.

Introduction

I have been encouraged and supported by my line manager to pursue and complete the Stage 2 Training. This has involved working within the Physical Health Psychology Team in a local NHS Trust, and has provided me with a wide variety of experiences, which are reflected within the chapters of this portfolio in order to demonstrate the expertise and skills required to achieve Health Psychologist status.

The main areas of my work have been across the fields of Pain Management and Diabetes Management and involve enhancing self-management skills of patient populations and supporting multi-disciplinary staff in facilitating health behaviour change. My work has seen me interact with patients, their families and health care professionals.

Chapter 1 Consultancy

My consultancy competence was met outside of the traditional healthcare setting. Having an interest in arts and crafts, I was employed by a local businessman to assess and evaluate the potential benefit that engaging in crafts could provide for general health and wellbeing in the local community. This fulfilled an area of personal interest for me, however, was in addition to my normal workload and as such required effective time management skills to be able to complete this alongside my clinical caseload. The resulting case study of a consulting project which aimed to explore the potential well-being effects of engaging in crafting is enclosed.

Chapter 2 Interventions in Health Psychology

Within my role as Associate Psychologist I aimed to deliver therapeutic interventions for patients referred from the medical specialities: Oncology, Renal, Diabetes, Respiratory, Long Term Conditions, and Pain Management. My role involved working on an individual or group level to assess, formulate, design and deliver interventions and then evaluate those interventions. Case studies summarise two such interventions are presented in this chapter.

Chapter 3 Teaching and Training

Throughout my training I taught healthcare professionals, patients and peers. Teaching and training provided me with an opportunity to impart health psychology knowledge across several settings, both within acute and community healthcare settings.

A teaching series has been chosen to present within this portfolio, with my reflective report, covering a number of individual teaching sessions. As expected, the opportunity to be involved in a range of teaching opportunities has been beneficial in terms of improving my training and teaching style, as well as my confidence in delivering training to a wider variety of audiences.

Chapter 4 Research

The research presented here is a development and extension of a research piece conducted at MSc level. Having designed and delivered a health behaviour change training for diabetes specialist nurses, I was frustrated to see that despite their reports of finding the training appropriate and suitable, they did not appear to implement in into clinical practice. This study sought to explore, using the TDF and COM-B the barriers to implementation, and to ultimately design a more effective training that could be easily integrated in routine clinics. While recruitment rates were low, what emerged is, I feel, a robust, standardised health behaviour informed intervention which provides both commissioners and staff with the tolls to implement change.

Chapter 5 – Professional Development; Reflective Commentary

This portfolio demonstrates the skills and knowledge of a trainee Health Psychologist and how all the various competencies have been achieved. It consists of case studies on professional skills, consultancy, teaching and training and intervention to elicit behaviour change. The doctoral programme has provided many opportunities to put skills into practice such as designing research interview schedules, critically evaluating previous research, writing up the findings and completing my own piece of research.

Over the past two years, it has been a practical learning experience, during which I have grown in confidence and feel I have developed my skills as a Health Psychologist within

the NHS. There have been personal challenges along the way, but these have added to the training in their own way.

As I approach the end of Stage 2, I am conscious of opportunities and challenges as I pursue a permanent role as a Health Psychologist but feel more than ready to embrace these.

Chapter 1: Consultancy

The Potential Health Benefit of Participation in Crafting.

Introduction

Craft workshops have become increasingly popular in recent years and according to Yair (2011), physical, mental and emotional wellbeing can all improve as a result of participating in craft as a leisure activity. From a personal perspective the ability to switch from general day to day activities such as work and family commitments to a more creative activity offers not only an escape but also allows an element of balance as the more creative part of the brain gets exercised. It is this balance that is generally what referred to when we talk about well- being.

Well-being is generally understood as a key determinant in maintaining physical and mental health yet is not clearly defined. Jones (2018) describes wellbeing as being the foundation of our choices related to relationships, how we contribute to society, lifestyle and work.

Consultancy Executive Summary

Creative Health: The Arts for Health and Wellbeing (2017) – presents strong evidence that supports the theory that creative and cultural activities can effect a positive impact on wellbeing. This consultancy report sought to explore this theory at a local level.

The Client established the [redacted] in 2019. He is an accomplished businessman who has many years' experience in promoting local crafts. [redacted] was established to both further promote local craft and to provide a creative space for those wishing to pursue arts and crafts in a relaxing and non-threatening environment. During the months of July and August 2019, a series of nine craft workshops were delivered. One of these workshops (Pyrography) was facilitated by a Trainee Health Psychologist, and as such was explored from the perspective of how beneficial crafting could be for health.

3 participants of a potential 12 engaged with the pyrography workshop, all of whom agreed to complete a short assessment tool and share their experience of the current workshop and any previous experience they felt was relevant.

Results from this small group indicate that marginal improvements in wellbeing were achieved as assessed by the Short Warwick-Edinburgh Mental Wellbeing Scale. However, observational evidence, supported by participant self-report indicate that both this workshop and others impacted positively on wellbeing, and in fact was employed by one of the participants on this occasion to help manage a particular episode of both physical and mental ill health.

Further investigation is required to explore this further with a larger group across a range of craft disciplines to be able to generalize results.

Related Work

Creative Health (2017) identified that engagement with the arts can begin to address obesity, help with mental health, long-term conditions, healthy aging and health inequalities. While this evidence has been slow to emerge, it is not new information to those involved in the arts and culture community. With the focus of healthcare turning to how we can best support individuals outside of traditional healthcare methods, greater attention is being paid to alternatives within our communities. While social prescribing has received a great deal of attention in recent times (England, 2019), the general community has a responsibility to look after each other, and sharing in small group activities that target The Five Ways to Wellbeing (Aked, 2011) is one such way to do this in a respectful and often empowering way.

Crafting in its various forms has been the subject of investigation over recent years, with some areas more heavily investigated than others. Corkhill et al. (2014) explored the effects of knitting on the experience of chronic pain and found that it had the potential to facilitate wellbeing and that it was clinically proven to raise levels of serotonin (mood-enhancing) and induce relaxation. Other studies in this area have explored the potential benefits of knitting in managing and combatting compassion fatigue in Oncology nurses Anderson (2016); and the ability of textile crafting to support the wellbeing of vulnerable men Green (2017). These studies highlighted that crafting had a significant impact on managing stressors and improved social connectedness both with those involved in

crafting and others encountered throughout daily life. It also illustrated how crafting allowed an alternative means for expression of emotion, both in the individual and group level. For those involved in healthcare, it helped them combat compassion fatigue, which in turn meant an improvement in the quality of patient care and also in rates of staff retention. One area that was highlighted in Green (2017) work was that solitary crafting may not be as beneficial for men as it has previously been shown to be for women.

Consultancy

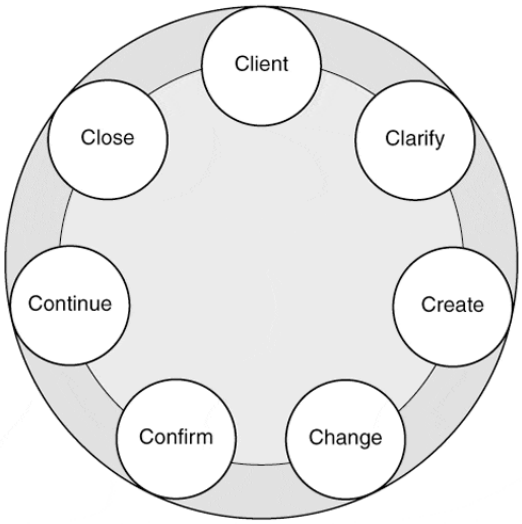
Consultancy can be defined as the act of giving expert advice within a given field. It is generally utilized by those who want to understand the what and why of particular scenarios prior to deciding if change is required and the most efficient way of implementing it. In this instance, the consultancy is not necessarily tasked with the job of deciding if change is required or to determine an effective style of implementation. In this case it is simply about giving the client more formal information that supports or discredits his hypothesis that crafting is beneficial for wellbeing.

This piece of work acknowledges that wellbeing is not easily defined. As such it employs mixed methods to measure any possible impacts that a single session pyrography workshop can have on wellbeing at a local level.

The timing of this consultancy piece was not great, with a very small window of time to plan. Also, initially, it did not appear entirely related to health psychology and while interesting to me and a small population of like-minded individuals, the outcomes were unlikely to be generalizable or possibly of much interest to others.

This piece was planned within a very short timeframe, as such it did not consider the range of consultancy models that exist at the outset. However, having explored these retrospectively, I feel that Mike Cope's 7C's (Cope, 2003) model of consultancy fits this piece of consultancy best.

Figure 1. Mike Cope's 7 C's



In exploring some of the other models I can also see how I might have fallen into the 5 P's model of strategy/consultancy (Mintzberg, 1987) easily as well.

The 5 P's are as follows:

- Plan: Plan/Set Goals
- Pattern: Explore what patterns exist
- Position: How does the business wants to position itself
- Perspective: Perspective of employer, employee and target audience
- Ploy: Implement a ploy/plan to achieve target/goal.

It is clear that the models are useful in terms of maintaining focus on the relevant areas of consultancy, however, having proceeded without following any particular model, I feel that they are perhaps more useful in the initial stages to help the consultant focus the client on what it is they want from the consultancy. They also have a purpose at the end of the consultancy period in helping focus the ensuing report that is developed. The 7C framework proposed (Cope, 2003) is meant as a guide, not necessarily a rigid process that requires strict adherence, however for the purposes of this report we will take each section in turn and apply them to this consultative process.

The Seven C's of Consulting

Retrospective application of the 7 C's model of consultancy starts the process with the Client.

Client

In this instance an existing relationship between The Client and myself (The Trainee) was established 4 years ago when a hobby evolved into a small business opportunity. I have been creating and supplying wooden products personalized or embellished using pyrography to The Client on a weekly basis for the past four years. In this time we have developed a good working relationship, which when it comes to the process of consulting I am not necessarily sure is a positive factor (discussed in greater detail on pages 6 & 7 below).

As already established, a prior relationship with The Client as a craft supplier had been well established over a number of years. As a result of this relationship I had agreed to facilitate two craft workshops over the course of a day in August 2019. This was to be one of a series of nine weekly workshops delivered during July and August 2019. Following the first workshop (Knitting) in early July, The Client was accepting a delivery from me when he started talking about his idea to look at the potential health and well-being benefits crafting held for those that participated in them. This was something that we had previously discussed in a very informal way when he was initially opening [redacted]. However, on this occasion he was much more focused on developing a greater understanding of the potential health and well-being benefits as he was keen to pursue local council funding to deliver craft workshops on an ongoing basis. The Client was aware of my full time occupation as an Associate/Trainee Health Psychologist and on this occasion asked if there was a way of developing our conversations into a more formal exploration of how crafting might positively impact health and well-being. Essentially what had started out as a routine delivery for me had developed into the beginning of the consulting process, something I can now admit, I was not fully prepared for. As a result it was a quick discussion which allowed me to get a sense of what he wanted to achieve and how I might be able to assist.

The 7C's framework, being a simplistic model, means that it can be applied within a short timeframe, 'Rapid Mapping' (Cope, 2003), to develop an understanding of the client's needs and for both parties to establish if this is a project they wish to pursue together. This initial discussion then is not just about the client but allows a quick run through the entire model, this then needs to be revisited and built upon over time to allow a full picture to be established before any commitment to a full contract is made. In hindsight,

this ‘rapid mapping’, followed by a few other very short conversations was really the basis of my contract. Having completed the consultancy and reflecting on it as I work through this model and case study it is clear that this was not the best foundation to begin from. If I go back at this stage and fully address Stage one: Client, I can see how the existing relationship between The Client and myself allowed me to proceed with the consultancy despite progressing the rapid mapping of the framework further.

Cope, M. (2003) talks about four issues that are essential when establishing good engagement with a client:

- Understanding who the client is, who the end consumers might be, and what primary role might I have in the relationship?
- How do they make decisions, are they ruled by emotions or logic?
- Do they trust me or can I do anything to expedite this?
- What style should I use to build the relationship, social or product based?

As I reflect on the engagement process I believe that all these issues had been addressed both prior to and during this initial consultancy meeting. The pre-existing relationship meant that I had many opportunities to observe how the client made decisions, we had developed a mutual trust over our 4 years of knowing each other in a product based way initially, moving to a more social model as we progressed. The potential end consumers in this instance were individuals who experience physical or mental ill health which impacts on their well-being, a population that to some degree I work with as a result of my full time employment. The main issue for me was my primary role in the relationship; consultant; supplier; friend or facilitator? This is where the pre-existing relationship with The Client presented some difficulties for this consultancy relationship. The fact that I had already agreed to facilitate the workshop meant that it was very difficult to refuse to do an additional piece of work at that time. Concerns regarding the timeframe, the small sample size and the inability to generalize results were all highlighted, but felt not important in the client’s eyes. There was also the fact that I was keen to get a competency underway and completed which created an internal pressure for me. In another situation the external and internal pressure to complete the consultancy may have caused an imbalance in the relationship between client,

consultant and consumer. In this scenario I feel that the imbalance between the client and consultant negated each other, and therefore did not negatively impact the consumer.

The consumers in this particular case are individuals who have physical or mental health difficulties that negatively impact on their wellbeing, and who frequent [redacted]. While the client is primarily a business man, working from a place of logic, he is also a very caring individual and someone who recognizes and rewards loyalty. In our early conversations he detailed how there were a number of individuals who he felt had become regular visitors to the coffee shop. He had noted their physical health difficulties and how they chose a particular area to sit in each time (possibly because of the type of seating), and how they spent quite some time appreciating the crafts displayed. He had also engaged in conversations with these and other individuals on different occasions and felt that there was a potential demand/need for crafting opportunities locally. The caring part of him wanted to deliver these opportunities, however, knew that financially he would not be in a position to offer these free of charge, and that many of his patrons would not be in a position to pay for them. The logical part of him had identified a potential local funding source but needed more than observations and feelings to complete a funding application successfully. He therefore identified the consultancy as a potential vehicle to offer him the language and background knowledge that he might need to complete such applications. In this regard the client was open to both the logical and emotional aspects of the consultancy and allowed me as the consultant to move interchangeably between the two, this enabled and facilitated the relationship between client and consultant further.

In any relationship, personal or professional, trust is also a vital foundational element. It must exist in some manner prior to the relationship to give the client the confidence to engage with you rather than someone else, however it requires cultivation in order to fully maintain the relationship. Again, the prior relationship between the client and consultant enabled this part of the process. Having worked together in a professional capacity over time allowed both parties to develop an understanding of each other. The degree to how consistent, reliable and predictable each party is had been long established prior to the consultancy, the client was also aware of the training of the

consultant and felt that this was a piece of work that they could safely deliver in an agreed time scale.

While Cope (2003) goes into greater detail around other aspects of the client aspect of consultancy, these were not particularly relevant in this particular context. This is due in part to the already established relationship developed between the client and consultant but also due to the fact that in this case the client was not focused on creating large scale change and as such issues such as change drivers were not felt to be particularly relevant. However contract negotiation is important in any consultancy piece and possibly more so in a scenario where there is a prior relationship. In negotiating this contract, the objectives of both the client and consultant were similar, however, the timescale and manner in which they would be achieved in required negotiation and collaboration to achieve a balanced outcome for both parties. The client approached the consultant 4 weeks before they wanted the consultancy to begin, which did not allow much time for negotiation, however it was important for me as the consultant to highlight a number of issues. While I was keen to get this competency underway and completed I was also keen to make sure it was something that would be of benefit to the client in the longer term. In my opinion, this piece of consultancy would have been much more robust had it been considered at the outset of the series of workshops. It would have been able to access a larger sample size across a range of craft disciplines, with time to explore established standardized measures and as a result would have been a much more substantive piece of work. In this respect I suggested running a second series of workshops later in the year and conducting the consultancy at that time. Unfortunately the timescales involved in the funding application did not allow for this and we agreed to move forward with the consultancy with the client being fully informed of the risks and the reality of the potential limitations of the ensuing report. As the consultant I felt it important to work towards what the client had requested, I was also keen (from a study perspective) to achieve this competency, however, I felt it was only right to leave the client fully informed of the risks of proceeding so quickly. While this might have been seen at one point as resistance, I feel that ultimately the client respected this level of negotiation as it illustrated professionalism, integrity, honesty and understanding, all of which left the client feeling safe that the consultant was competent and capable to proceed.

The potential issues discussed are listed below:

i) I would have a dual role as both workshop facilitator and consultant;

ii) I am a novice in consulting;

iii) The evaluation proposed did not allow much time for planning;

iv) The evaluation proposed involved only one craft discipline; and

v) Assumed that all participants of the workshop would be happy to also participate in the evaluation.

vi) Any results would not be generalizable due to the small numbers (maximum 12) involved.

These were discussed at length during a face to face meeting with the Client, and while they understood the concerns they chose to proceed.

Clarify

This stage involves trying to understand exactly what the problem is and where it's coming from. In this case, there is no 'problem' as such, however it is still important to clarify exactly what the client is trying to achieve through the process of consulting. Cope (2003, p.86) detailed eight distinct steps to the process of clarifying, as follows: Diagnosis; Phase Mapping; Shadow Dancing; Culture; Decision Makers; System Construction; Stakeholders; and Life-cycle risk. During this consultancy the first two steps were given the most consideration, the others were not considered in detail as they relate primarily to the process of change that any consultancy piece may direct. As there was no distinct change involved as a result of this piece of work they were deemed not entirely necessary to explore in any great detail although an awareness of their existence was held throughout. The first two steps of diagnosis and phase mapping are discussed below.

Diagnosis involves collecting all the information that is required to determine the source of the problem. As mentioned above, while there was no problem, the client had a hypothesis that crafting would improve the physical and emotional wellbeing of those who participated in it. The client had identified that my role as a trainee health psychologist, addressing the emotional needs of those with physical health difficulties, as well as my role as a 'crafter' left me perfectly positioned to explore this hypothesis further. Having been involved in craft I was acutely aware of how it facilitates a

meditative state as attention is focused on a task; pacing and goal setting in the pursuit of the end product, and the sense of relaxation that this promotes. All of these mirror in many ways the skills imparted in for example the pain management program facilitated in my daily work.

The knowledge of this hypothesis allowed me as the consultant to identify what information was required to prove or disprove it. How that information might be collected also required attention at this stage as well as how it might be analysed. This alongside the richness of the information, given the small numbers anticipated required serious consideration and was discussed at length with the client before proceeding with the consultancy. As the consultant, given the nature of the work involved, my preference in collecting this data would be primarily through a focus group. However, due to the dual nature of my role as both facilitator and consultant, I felt that capturing this information solely through a focus group approach may not be entirely possible, as I may be unable to record accurately at the time. As such I also employed a standardized well-being questionnaire (see below) which allowed me to capture independent pre and post measures, as well as my retrospective recall of the discussions throughout the workshop to provide a full picture of the information gathered.

Phase mapping involves exploring how all the different components in a system might relate to each other, again a concept that in the business world, when working with large teams and organisations might be very important, however maybe not so much in a smaller scale piece of work such as this. However, it is important to consider any known and unknown factors which may have an influence on the outcome of the consultancy. In this case, the participants were the unknown factor; how many would take part in the workshop (open registration); how many would agree to participate in the consultancy; their previous experience of crafting; and how comfortable they might feel as a group to discuss issues around physical and emotional wellbeing. This aspect of group cohesion, as well as my dual role as facilitator and consultant, further supported the use of standardized pre and post measures.

This stage of the consultancy required less consideration that it might have done had I been employed by a company I had little knowledge of, was larger and had greater change in mind. My prior knowledge of this business and the client meant that I was

familiar with the settings and the culture. The consultancy piece itself was of a small scale and as such did not present the same level of risk that a larger scale piece may have. However, having clarified the issue and how it might be addressed, I was able to progress quickly to the next stage of creating a solution.

Create

The third stage – create, in the context of this consultancy holds a number of meanings. Obviously the meaning within the model of consultancy is to create a tailored solution that will offer the client an answer to their problem. For the most part, the client in this scenario had already created part of the tailored solution, however required me to provide a framework around that which would, for want of a better term, qualify it. My role at this stage, given the previous discussions around what the issue was and how we might address it was to identify the standardised assessment tool that might be applied to give the best result in this case.

I identified an article by Nevay et al. (2019) which had employed the Warwick-Edinburgh Mental Wellbeing Scale which prompted me to explore this measure further. It was developed in 2007, is positively worded and relates to the positive attributes of mental health (Stewart-Brown et al., 2011). What encouraged me to look into this option further were what Clarke et al. (2011) described in their paper as the main attributes; positive focus; good face validity with public, public health professionals and policy makers; ease of completion and its clarity. Furthermore Shah (2018) had explored its responsiveness to change at both individual and group levels and found that a change of between 1 and 3 points met the threshold for statistical change. Given the small numbers expected to participate in the workshops, and a desire to engage them, it was decided that the Short Warwick-Edinburgh Mental Wellbeing Scale (7 item) would be the most acceptable to participants while still producing results that would be suitable for reporting in any funding application.

While a measure of mental well-being was employed in this consultancy piece ((S)WEMWBS), the gathering of participants reflections, revealed in their conversations and observationally in their interactions was a key factor to understanding their experience of participating in a craft workshop and the impact this had on their well-being. Throughout the workshop managing the dual role of both participant (supporting, conversing and problem solving) and observer (of activity, and

interpersonal interactions) was much easier than initially anticipated. This may have been more difficult however if the numbers originally anticipated over both workshops had been involved.

While the client was not keen on using any standardized measures, as they felt they would not be acceptable to the participants of the workshops and potentially disengage them, as the consultant I stressed the importance of such measures for any ensuing report. I also discussed the rationale behind the particular measure proposed and the client understood the reasoning for its use and was happy to proceed to the next stage.

Change

While on the face of it, this consultancy does not require large organizational change, if we look closer at the themes involved in change we can see where these are important in this consultancy. Themes such as, system dynamics, organization, and resistance are all part of change – they are all the human elements of change. In a larger piece of consultancy they would require much more consideration, however due to both the small scale and the client being the sole driver for change, having engaged them well from the outset and collaborated closely throughout, this stage required very little attention. In a similar vein, although each of the next three stages were given consideration, they were less distinct in this consultancy as they may have been in a larger piece and as such will be considered together.

Confirm, Continue, Close

Having introduced the use of the standardised measures from the outset, a measurement process had been established and it was important as we progressed through the consultancy to manage this process by completing it by re-running the measures at the end, confirming any change that had taken place. While the time (2.5hrs) between pre and post measures was relatively short in terms of assessing any effect, I felt it was useful to identify any change no matter how small. In an ideal scenario assessment over a longer period of time would be preferable. As mentioned previously, the discussions had throughout the workshop also formed the basis of a focus group intervention and these were recorded retrospectively on completion of the workshop, so that this data could then further add to the data obtained in the standardised measures. Having brought all the information together and produced a report that was submitted to the client, in order that they could understand and utilize the information

in a way that fully met their needs, a further meeting enabled the client to explore any areas that were not clear. This ensured that the 6th stage – Continue, had been addressed, as the client was able to progress with the funding application, supported by both experiential and observational data, which was then enhanced with evidence from not just this consultancy but other studies that had been conducted previously and were reported on in the client report.

Closing the engagement is the final step in the 7Cs model of consulting and is equally important to manage well as the initial steps. At this stage it is important to reflect on the process; what was learned and have the outcomes been achieved. It is also important to ensure that the client has everything they need to proceed from this point further and that the work has added value in some way to their company. Ensuring that all the aspects above have been given due consideration should leave the consultant in a position to close the piece of consultancy but leave themselves in a position to pursue further options with this client in the future. In this piece step 7 was achieved seamlessly, even though it was possibly not given full consideration at the time. This was evident when the client offered their feedback on the report; they described feeling much more confident about the funding application that they had prepared and highlighted the supporting evidence of previous research as one of the areas that they felt they benefited most from. They described how they felt this gave them the language style required to answer the questions posed in a more succinct yet comprehensive manner. The funding application had not been processed at the time of closing the consultancy however, I am aware through my contact with the client in my capacity as a supplier that the application was submitted and successful shortly thereafter.

I also felt that it was important at the closing stages to revisit the issues that I had highlighted at the outset to examine if, in retrospect, the client felt they had been addressed adequately. The issues I had highlighted were:

i) I would have a dual role as both workshop facilitator and consultant;

ii) I am a novice in consulting;

iii) The evaluation proposed did not allow much time for planning;

iv) The evaluation proposed involved only one craft discipline; and

v) Assumed that all participants of the workshop would be happy to also participate in the evaluation;

vi) Any results would not be generalizable due to the small numbers (maximum 12) involved.

The client reported that they had no concerns at the outset of the consultancy about issues i) and ii) and described how they had discarded issue ii) down to a lack of self-confidence on my part. They stated that while they could understand my concerns about the dual role, they felt this had been managed well and did not appear to have affected the overall outcomes. In this case, it did appear to work, however, had both workshops been fully subscribed, this may have been a bigger issue for me. The fact that both workshops had not been fully subscribed was also addressed at this point. The client had taken responsibility for advertising and recruiting to the workshops, which had begun before I was contracted to conduct the consultancy. In any further work, this is something that I would insist on managing myself so that maximum benefit could be achieved. While the morning workshop only had half the potential number of participants anticipated, in this instance, with these particular participants, I feel this worked in my favour. The afternoon workshop had no participants subscribed, so I was able to use this time to record my recollections of the discussions held with the previous participants. During this time, my workshop equipment and some examples of work were visible and a number of individuals approached me stating that they had meant to sign up but had either forgotten or had other commitments. This highlighted the importance of advertising well in advance and following up with earlier enquiries and I discussed this with the client. He felt that this was something that required attention in future workshops but felt that while only one workshop had been fully completed, this was something that was outside of my control. The fact that I remained available in the afternoon and engaged with potential future participants meant that he was happy that the contract had been fulfilled on my part.

The client was also able to more fully understand the other issues that had been highlighted in the initial stages of consultancy. Having witnessed the small numbers participating, he was able to see how there may have been no consultancy at all had the participants chosen not to take part in that element of the workshop as it had not been highlighted from the outset, we were particularly lucky on this occasion. While the consultancy report enabled him to pursue his funding application successfully, he was

able to identify how much more informative and worthwhile this consultancy might have been if it was conducted over time and a range of craft disciplines. This is something that he is keen to pursue in the future.

Reflections

In writing a report for the client and subsequently this reflection, I can only describe this piece of consultation as something of a 'baptism of fire'. It was in my eyes, an opportunity to achieve a consultancy, and as such I feel that in my eagerness to get one competency completed, I rushed in without thinking it through fully. The process of developing a contract and agreeing that with the client felt foreign and unnatural, most likely this was enhanced given our previous, much less formal relationship. In retrospect, if I was asked to do a similar piece of work in the future I think I would more assertive and decline the offer, or at the very least negotiate a more robust piece of work, exploring a number of craft workshops across disciplines and with greater numbers of participants. I would also work through a model of consultancy from the outset rather than apply it retrospectively, and I think this in itself would assist me in being more assertive. My next piece of consultancy will address the issues highlighted here and take more time to work through a model of consultancy from the outset.

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Contract of Consultancy

Private Contract: Delivery of a Single Craft Workshop (Pyrography) to assess the potential Health Benefits of Crafting. This will fulfil the Consultancy Competency for Fulfilment of Professional Doctorate in Health Psychology

Contract of Consultancy

Private Contract: Delivery of a Single Craft Workshop (Pyrography) to assess the potential Health & Wellbeing Benefits of Crafting. This will fulfil the Consultancy Competency for Fulfilment of Professional Doctorate in Health Psychology.

This contract is made on the __5th___ day of the __7th___ month 2019, between [redacted], hereafter known as the CLIENT, and TRACY MCCROSSAN, hereafter known as the Trainee.

Supervisor's Name Helen Poole / Rachel Tarling_____

The supervisor will provide guidance on negotiation of the contract.

Supervisor's signature _____

Date _____

Witness _____

Trainee's signature _____

Date _____

Witness _____

Nature of the Contract

The Trainee agrees to provide a Craft workshop (Pyrography) for up to 12 individuals, in 2 sessions, am(10.00am – 1.00pm) and pm(1.30pm – 4.00pm) on Thursday 1st August 2019, from 10am – 4.00pm at [redacted]. The Trainee will provide all equipment required for the workshop and on completion of the workshop will furnish the Client with a report outlining the potential health & wellbeing benefits of "one-off craft workshops" based on the information gathered on 01/07/19.

Standards of Conduct

The Client agrees to advertise the workshop and deal with any bookings, taking account of the name and contact number of the individuals involved. The Trainee agrees to be set-up and ready to proceed by the agreed time (10am) and finish by the agreed time (4.00pm) on the agreed date (01/07/19) and to produce a report within 1 Calendar month following the commencement of the Workshop (01/08/2019). The Trainee agrees to be bound by the ethical codes of conduct published by the British Psychological Society, as well as professional standards in keeping with the Health and Care Professions Council.

Payment of Fees

The Client agrees to pay a flat rate of £140 for the Trainee's time (10am – 4pm), while the Trainee will meet the cost of his/her own equipment and travel on all occasions.

Illness, Disability or Death

In the case of a medically certificated long-standing illness or disability which prevents either party from continuing with this arrangement, the contract shall terminate. In the case of incapacity on behalf of the Client, he or his agents will make reasonable arrangements to facilitate the Craft Workshop on the agreed date or at a later date if this is necessary. Death of the Client shall result in his agents taking a temporary

suspension of the contract or in termination of the contract. Incapacity of the Trainee will result in either a temporary suspension of the contract or a termination of the contract, to be decided by the Trainee depending upon her circumstances. Death of the Trainee shall result in termination of the contract. In all cases, fees paid will be non-refundable.

Limitation of Liability

The Client shall provide a safe environment for both the Trainee and any participants of the workshop in keeping with the terms of Public Liability Law. The responsibility for creating, maintaining and presenting for examination a suitable report regarding the potential benefits of participating in a craft workshop on health, and for performing to the required standard in delivery of said workshop, remains that of the Trainee. The Trainee will also ensure that they hold the relevant insurance documentation to be able to conduct a craft workshop using pyrography to the general public.

Ethical Clearance and Insurance

The Trainee is solely responsible for obtaining appropriate ethical clearance for all work undertaken under the auspices (whether joint or otherwise) of this contract and the Stage II Qualification. In addition, sole responsibility for obtaining professional indemnity insurance to cover all parties' rests with the Trainee and her employers (where appropriate) and not with the Client.

Publications and Intellectual Property Arising

The Client reserves the moral right to negotiation of shared authorship of publications arising from work carried out under this contract, in keeping with standard academic practices. This is without prejudice to any contracts that either party have with their employers or other parties, and where appropriate.

The Client reserves the moral right to negotiation of shared royalties and/or profits from inventions or other intellectual property arising from work carried out under this contract, in keeping with standard academic practices, and where appropriate. This is without prejudice to any contracts that either party have with their employers or other parties.

Client Report

The Potential Health Benefit of Participation in Crafting.

Introduction

Craft workshops have become increasingly popular in recent years and according to Yair (2011), physical, mental and emotional wellbeing can all improve as a result of participating in craft as a leisure activity.

Well-being is generally understood as a key determinant in maintaining physical and mental health yet is not clearly defined. Jones & Randall (2018) describe wellbeing as being the foundation of our choices related to relationships, how we contribute to society, lifestyle and work.

Executive Summary

Creative Health: The Arts for Health and Wellbeing (2017) – presents strong evidence that supports the theory that creative and cultural activities can effect a positive impact on wellbeing. This report sought to explore this theory at a local level.

The [redacted] was established in 2019 by an already accomplished businessman who has many years' experience in promoting local crafts. The Cottage was established to both further promote local craft and to provide a creative space for those wishing to pursue arts and crafts in a relaxing and non-threatening environment. During the months of July and August 2019, a series of nine craft workshops were delivered. One of these workshops (Pyrography) was facilitated by a Trainee Health Psychologist, and as such was explored from the perspective of how beneficial crafting could be for health.

3 participants of a potential 12 engaged with the pyrography workshop, all of whom agreed to complete a short assessment tool and share their experience of the current workshop and any previous experience they felt was relevant.

Results from this small group indicate that marginal improvements in wellbeing were achieved as assessed by the Short Warwick-Edinburgh Mental Wellbeing Scale. However, observational evidence, supported by participant self-report indicate that both this workshop and others impacted positively on wellbeing, and in fact was employed by the participants on this occasion to help manage a particular episode of both physical and mental ill health of one of the participants.

Further investigation is required to explore this further with a larger group across a range of craft disciplines to be able to generalize results.

Related Work

Creative Health (2017) has identified that engagement with the arts can begin to address obesity, help with mental health, long-term conditions, healthy aging and health inequalities. While this evidence has been slow to emerge, this is not new information to those involved in the arts and culture community. With the focus of healthcare turning to how we can best support individuals outside of traditional healthcare methods, greater attention is being paid to alternatives within our communities. While social prescribing has received a great deal of attention in recent times, the general community has a responsibility to look after each other, and sharing in small group activities that target The Five Ways to Wellbeing is one such way to do this in a respectful and often empowering way.

Crafting in its various forms has been the subject of investigation over recent years, with some areas more heavily investigated than others. Corkhill (2014) explored the effects of knitting on the experience of chronic pain and found that it had the potential to facilitate wellbeing and that it was clinically proven to raise levels of serotonin (mood-enhancing) and induce relaxation. Other studies in this area have explored the potential

benefits of knitting in managing and combatting compassion fatigue in Oncology nurses Anderson et al. (2016); and the ability of textile crafting to support the wellbeing of vulnerable men Green (2017).

Consultancy can be defined as the act of giving expert advice within a given field. It is generally utilized by those who want to understand the what and why of particular scenarios prior to deciding if change is required and what might be the most efficient way of implementing it.

This piece of work acknowledges that wellbeing is not easily defined. As such it employs mixed methods to measure any possible impacts that a single session pyrography workshop can have on wellbeing at a local level.

Context

[redacted] is one of three well-established craft shops situated in the [redacted]. It is managed by The Client and sells high-quality hand produced crafts to locals and tourists alike.

In January 2019, The Client agreed the lease of the adjoining [redacted], with the intention of creating a coffee shop which would promote a creative space for locals. As part of this initiative and following conversations with a few individuals he realized that many of his suppliers and those who frequented [redacted] used craft to self-manage both physical and emotional health difficulties.

To explore this further from an observational perspective, he arranged nine craft sessions over July - August 2019, one of which was a Pyrography (fire writing) workshop, facilitated by the author of this report.

The Workshop

As highlighted above, the Trainee had already been contracted to facilitate a craft workshop (pyrography) as part of a series of craft workshops organized in an established [redacted]. Prior to the workshop the Trainee was again approached (this time in their role as a Trainee Health Psychologist) to see if they would carry out a

more formal evaluation of how participating in the pyrography workshop impacted on physical health.

The prospect of such an evaluation, while attractive, highlighted a five potential issues:

i) The Trainee would have a dual role as both workshop facilitator and consultant;

ii) The Trainee is a novice in consulting;

iii) The evaluation proposed did not allow much time for planning;

iv) The evaluation proposed involved only one craft discipline; and

v) Assumed that all participants of the workshop would be happy to also participate in the evaluation.

vi) Any results would not be generalizable due to the small numbers involved.

These were discussed at length during a face to face meeting with the Client, and while they understood the concerns that were noted they chose to proceed with the evaluation.

In the facilitation of the workshop participants were therefore invited to complete an outcome measure examining their Mental Well-being at the beginning and end of the workshop. They were also encouraged to give qualitative feedback on their experience and how they felt it impacted on their physical and emotional wellbeing.

The date of 1st August 2019 was agreed for the workshop and the Client advertised a morning and afternoon workshop with space to accommodate 6 participants at each. Uptake was limited to three females in the morning workshop. The Trainee arrived as agreed at 9am to set-up, ready to proceed with the workshop starting at 10am.

The first of the three participants arrived at 9.45am excited to get started. She informed the Trainee that all three participants were friends and had actively engaged in a variety of craft activities previously, however had never tried pyrography. The other two participants arrived at 9.55am, both exhibiting limited mobility (one using a stick and the other using a walking frame). It took a little time to get everyone seated and comfortable and go through some introductory information.

The Trainee explained what Pyrography was and established that everyone present was keen to proceed with the craft workshop. It was also explained that through this workshop the Trainee was keen to explore how crafting impacted on wellbeing, and as such would ask them to complete a short anonymised questionnaire both before and after the workshop if they agreed.

The Short Warwick Edinburgh Mental Wellbeing Scale was developed in 2007 and is positively worded with an original 14 item scale and the shorter 7 item scale. It has been verified for use with those over 13 years of age Clarke et al. (2011) and was employed here as a result of being both, easy to understand and respond to. It has been employed in other areas to assess the impact of interventions such as counselling, CBT and parenting skills programs on wellbeing. However, it appears that it has only been employed on one other occasion to assess crafting as a wellbeing intervention in Nevay et al. (2019).

All three participants agreed to complete the Short Warwick Edinburgh Mental Wellbeing Scale ((S) WEMWBS) which consists of 7 items. The Trainee also explained that any thoughts or opinions they felt happy to share about how crafting impacted their wellbeing would also be welcomed and anonymised for the purpose of this report. Photographs and videos were also captured during the workshop with participants' consent.

Following completion of the questionnaires, the participants were familiarized with the equipment, and instructed on the most efficient methods to obtain optimum results. They then choose their preferred canvas (heart shaped bamboo chopping board or platter style bamboo board). One of the participants choose to add the detail freehand while the other two choose to transfer the image to the board and burn the detail thereafter.

As they engaged in their 'burning' there were several social exchanges observed. Initially, these focused on the designs chosen and what they meant to them, this involved both an element of storytelling as well as 'catch-up'. There was an element of social connectedness here. The Trainee also observed the sharing of skills and use of problem solving when one member was unable to achieve an element of the design.

Rather than having to explain what needed to happen to facilitate the desired outcome one of the other participants shared what she had learned from her own work.

One of the participants required regular comfort breaks as a result of her physical health difficulties (fatigue and a tremor in her hand). The breaks were self-determined and as a result the participant noted at the end of the workshop that she felt empowered.

SWEMWBS were completed again before the participants finished their workshop.

While a measure of mental well-being was employed in this consultancy piece ((S)WEMWBS), the gathering of participants reflections, revealed in their conversations and observationally in their interactions were key to understanding their experience of participating in a craft workshop and the impact this had on their well-being. Throughout the workshop the Trainee managed a dual role as both participant (supporting, conversing and problem solving) and observer (of activity, and interpersonal interactions).

Outcomes

Unfortunately, the small number of participants did not allow for statistical analysis, however completion of the Short Warwick Edinburgh Mental Wellbeing Scale at the beginning and end of the workshop illustrated a marginal benefit in well-being for these individuals.

Furthermore, the self-reports given freely throughout the workshop support the hypothesis that crafting can benefit both physical and mental wellbeing, for these individuals at least.

Over the course of the workshop they detailed how all three have managed, diagnosed Long-Term Conditions for many years. They also reported that very recently one participant had been further diagnosed with an additional Long-Term Condition, which she found extremely overwhelming. This subsequently impacted on her mental health and she was currently an inpatient in a mental health unit as a result. Having utilized crafting to manage their own conditions in the past her friends recognised the benefits

of crafting for both emotional and physical wellbeing and arranged a short break from the unit with her healthcare team to allow her to attend this workshop in an attempt to "bring her out of herself".

As they crafted the participants talked at length about the various craft projects they had been involved in over the years, from pottery, basket making, knitting, and needle felting to name a few. They highlighted the importance of doing something that captured their attention to the degree that they were able to forget about their condition for a little while. Before their physical health condition, they reported that they had all worked and enjoyed the benefits that work afforded them, such as a regular income, social groupings, friendships, structure and focus to each week. When their physical health deteriorated to the point that they were no longer able to maintain their work they felt as if everything changed, and they reported how this then impacted on their self-worth and emotional wellbeing.

Crafting appears to have offered these participants a way of addressing many of the issues being unable to work as a result of their physical health presented them with.

They detailed how it offered them an opportunity to engage with others in a way that suited them. They could often do it a time that suited them; do it on their own or in a group; talk or not; stick to the tried and tested crafts when confidence was low and try new crafts when feeling physically and emotionally more able. The Trainee observed more than just the verbal interactions, at times they also physically interacted with each other, either leaning in to get a better view of their neighbours work or patting an arm or touching a shoulder, this appeared to convey a sense of camaraderie.

They described a feeling of achievement when they mastered something new or completed a piece they'd been working on for a while, and the pride they felt when a family member or friend commented on their creation.

Crafting also allowed for social interaction at a level that they felt was comfortable or acceptable and provided something of a therapeutic space at times. They described how working on a similar project side by side allowed for quiet reflection, general chit chat ("banter") or more in-depth discussions in a very non-threatening way that they felt was one of the greatest aspects of participating in small group craft workshops.

One of the participants detailed how she had gone to different craft groups/workshops in the past and by her own choice had very little interaction with other group members, however returned home that evening feeling that she had been involved in something worthwhile and had achieved something positive. This had a positive impact on both her emotional and physical well-being as she described having a better nights sleep, as she was exhausted from the activity of the workshop and the concentration involved, but also a sense of achievement and pride in the piece that she had produced.

As the workshop approached its end there were comments about signing their work, as they were so pleased with it; where they would display it in their homes; and how the workshop was so different to anything they'd done before, but how they felt so relaxed as a result of taking part.

The Five Ways to Wellbeing have been identified as 1)Connect, 2)Be Active, 3)Notice, 4)Learn, and 5)Give. If we take each of these elements and assess the impact of this workshop on wellbeing based on these, it appears from the conversations noted, the observations and the final pieces created that all five indicators of wellbeing were achieved.

Recommendations

This report is extremely limited as a result of the small number of participants engaged over a short period of time. It may be seen as more of a focus group exploring the potential interest in running craft workshops to facilitate well-being on a regular basis.

It was obvious from the outset that this group of individuals had extensive experience in crafts of various disciplines and as such they may not be entirely representative of the general population. They also had great insight about the benefit of being engaged in both crafts and small groups.

To fully explore the potential health benefits of crafting, a longer-term evaluation, with a greater number of participants across a range of craft disciplines would be recommended. To measure changes in well-being particularly in a setting such as this over such a short period of time is unlikely to produce any significant statistical data, however an observational study, exploring interactions and group discussions may elicit more useful data on the well-being benefits of participation in craft. It may also be

useful to run similar workshops at different times of the year. This series of workshops were run during the summer months which may have had an impact on both the uptake of the workshops and also the type of participants (being more suited to those on holiday and potentially ruling out participation of those with children who might normally be at school during the day). It may also be beneficial to consider the advertising of the workshops to facilitate greater uptake of the craft workshops which may facilitate greater interaction.

The use of the wellbeing scale and the observational data from the participants verbal and physical interactions indicated that wellbeing was positively impacted as a result of the craft workshop. As stated above, without a larger study exploring a more diverse group of individuals and potentially crafts we are unable to state categorically that it was the participation in this craft workshop that impacted on wellbeing. However, throughout the workshop it was evident that the participants enjoyed learning a new skill, were socially connected and while focused appeared relaxed throughout, all indicators of wellbeing. In conclusion, feedback received by the Trainee in the days following the workshop sums up the experience from one of the participants:

"This was THE BEST MORNING, we all had a great time with Tracy, so easy going, no pressure, all set up and ready to go. The workshop itself was so easy and relaxing, nothing too difficult to manage. We loved it."

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Chapter 2: Behaviour Change Interventions

Behaviour Change Intervention
Case Study 1

Introduction

This case study outlines an assessment, formulation, intervention and evaluation which was carried out within the Clinical Health Psychology Service. This secondary care service is part of an acute hospital setting offering psychological input to individuals with chronic physical health conditions in the following specialities: Oncology; Diabetes; Renal; Respiratory; Chronic Pain; Rheumatology; and Haematology. Individuals living with these conditions can often experience emotional difficulties such as; low mood, anxiety, adjustment issues, feelings of isolation, difficulty with symptom management and accepting limitations, and fear.

Referral Information

Mrs J, a 40 year old lady was referred to the Clinical Health Psychology service by the Consultant Endocrinologist working within the Diabetes Team. The referral indicated that she was aware of, and happy for the referral to be made. Medical Difficulties and Treatment History, were listed as Type 1 Diabetes Melitus (TIDM); on Continuous Subcutaneous Insulin Infusion/Insulin Pump (CSII) and currently requesting CSII holiday. The reason why psychology assessment and input is required was: "Feeling overwhelmed, and struggling with diabetes management".

Assessment

The standard assessment within the Clinical Health Psychology department follows a biopsychosocial model, this allows us as clinicians to identify a range of different factors that may contribute to an individual's overall physical and psychological health. This allows consideration of the many other factors, such as cultural, social and psychological (not just medical) contribute to health and illness.

Formal assessment is thought to begin when an individual enters the consulting room, however there are opportunities for informal assessment to begin prior to this. As a member of the diabetes multi-disciplinary team, there is often discussion about

individual cases prior to referral, and this can be the beginning of an informal assessment. When a referral letter is received, information contained is assessed, for example, Mrs J's referral stated that she was using a CSII, my assessment of this based on prior clinical experience tells me that she has been managing her diabetes extremely well until recently as CSII is not offered to those who have poor management. These pre-assessment nuggets inform and guide the more formal assessment.

A formal assessment in the format of a semi-structured interview was carried out over the course of a 60 minute session. Information was imparted to the client explaining the nature of the service, what it could offer, the limits of confidentiality, my role as a health psychologist in training, as well as the potential for onward referral. Once all queries had been addressed the client was asked to sign a consent form indicating that they understood the information given to them and they were happy to proceed. As stated above the biopsychosocial model (Engel, 1977) informed the assessment and as such information was sought from the client on areas such as medical history; presenting problems; current social context; mood; coping/strengths; family; educational and career history. The assessment follows that developed by Belar (2009) in an attempt to examine each potential area of interest so that a full picture of the situation is obtained prior to formulation and intervention. A self-report measure – the Health Anxiety and Depression Scale (HADS) (Zigmond and Snaith, 1983) was also completed. The scale was developed as a tool to detect anxiety and depression in individuals with physical health problems. While there has been some debate in recent years about its validity it remains widely used in medical practice. This may be due, in part, to the fact that it offers many clinicians a simple yet reliable tool to screen for the contribution of anxiety and depression, in the clinical setting Snaith (2002). However, it may also be due to the fact that it does not include variables measuring somatisation, unlike some of the other measures such as the Beck Depression Inventory (Beck et al., 1961). The HADS has been shown to give clinically meaningful results as a psychological screening tool, in clinical group comparisons and in studies with several aspects of disease and quality of life (Herrmann, 1997). While there are a range of diabetes specific assessment measures available, these are not routinely employed in our department unless there is a clear indicator for further investigation of a particular area of concern, which at this time was not the case. This gathering of information provides basis to develop a plan for

treatment and identifies problems, strengths and goals for intervention (Gamble, Brennan and RCN, 2006).

Presentation

The client arrived on time, was well presented, generally a good informant, and maintained eye contact throughout. She appeared to be well informed about the nature of her condition, but reticent to explore emotional aspects of her situation. I felt this indicated that she possibly had difficulties, or was unfamiliar with opening up about her feelings and as such emphasis was placed on core therapeutic skills such as empathy, warmth and unconditional positive regard in an attempt to facilitate openness (Rogers, 2004).

Medical History

Mrs J reported a 9 year history of diabetes, which she felt was managed well until approximately 2 years ago. At this time she had started to be less conscientious about adhering to her medication regime and was allowing her blood sugars to remain high, particularly in the evening. She was well aware of the risks that this posed to her health and how she might manage this, however felt unable to create a change in her behaviour. In terms of medical history, she noted trouble conceiving, and reported that her three children (1 girl 7yoa and twin girls 4yoa) had all been the result of IVF. She also noted that she was aware of being less physically active in the recent past than she was previously.

Contextual Information

Mrs J told me that she was currently living in her own home with her three children, having separated from her husband, following his affair with her boss approximately 2 years previously. She was currently in full time employment in a local accountancy firm during the week, and part time as a nail technician from her own home at the weekend, at this point she described how she preferred to “keep busy”, particularly on weekends when the children were with their dad.

She described herself as being “very independent” with a difficulty asking for or accepting help from others. She described situations where both her mother and sisters had offered advice and practical assistance, however she did not avail of this reporting that it was her duty to care for her children. She described a difficult relationship with both of her parents, but particularly her mother (who abused alcohol) in her teenage

years. This meant that Mrs J often had occasion to look after her own needs as well as those of her siblings.

She reported that her sleep pattern was poor; she generally went to bed with the children at 9pm but found it difficult to fall asleep (due to her head being 'busy') and often experienced early morning wakening (4-6am) with a heightened sense of dread, when her head would again become 'busy'. When the children were with their dad (1 night midweek and every other weekend), Mrs J reported being unable to fall asleep without the aid of her TV or phone. She reported a tendency to comfort eat on those occasions when she was home alone.

In terms of her goals for contact with psychology, Mrs J reported that she would like to be generally less anxious and prioritise her health. Successful therapy requires establishing relatively clear collaborative goals and utilising interventions that are relevant to those therapeutic goals throughout (Green and Herget, 1991).

Self-report measures

She described variable mood, noting increased anxiety , particularly in the morning, but throughout the day generally, with scores on the Hospital Anxiety and Depression Scale (HADS) (Snaith and Zigmond, 1986) supporting this, indicating moderate symptoms of anxiety with depression in the sub-clinical range. She denied any thoughts of life not worth living, and had previously availed of tele-health counselling sessions which provided her with a link to meditation in the past.

Formulation

A formulation is described by Butler (1998, p.2) as "*the tool used by clinicians to relate theory to practice… It is the lynchpin that holds theory and practice together… Formulations can best be understood as hypotheses to be tested."* It follows assessment and gives both the psychologist and service user a framework to understand the ensuing intervention and evaluation. A bio-psychosocial framework was adopted for the formulation as it offers a framework in which we can understand how physical health problems can be maintained and treated over time (Williams, 2002). The bio-psychosocial approach has developed over the years and builds on the early biomedical models, which have in more recent years been described as reductionist and exclusionary (Engel, 2012). The most recent model for understanding behaviour change proposed within the bio-psychological approach is the COM-B (Michie, van Stralen and

West, 2011), which links three conditions, namely Capability; Opportunity and Motivation to form a behaviour system.

If we apply the COM-B model to Mrs J's formulation it looks like this (note the text in red are the areas focused on in sessions, while the text in black was included for context/understanding):

Figure 1: COM-B Model

Behaviour

Capability

- **Physical**
  - Generally good understanding of TIDM
  - Previous Good Control
- Posses the skills for behaviour change
  - Posses the skills required for self management of hypo/hyper glycaemic attacks
- **Psychological**
  - emotional impact of relationship breakdown affects ability to process information
  - loss of focus on healthy diet due to relationship issues
  - no attention given to increasing physical activity
  - Diet and Physical activity level assesment being avoided
  - Maintaining high blood sugars in evening

Opportunity

- **Physical Context**
  - Healthy food available, financially able to afford
  - sole responsibility for children limits opportunities for physical activity
- **Social Influences**
  - Lack of Social Support
  - Managing everything on own

Motivation

- **Reflective Motivation**
  - **Social Role & Identitiy:**
    - Feelings of failure & blame; need to be a good mum (protect children); care for others, no time for self
  - **Beliefs Capability**:
    - believe lifestyle change is important; anxiety and emotional stress impact on perceived self efficacy
  - **Optimisim;**
    - Optimistic that change is possible
  - **Belief Consequences:**
    - awareness of role of lifestyle in managing condition; increased motivation to protect children
  - **Intentions:**
    - commitment to change evident in attending psychology appointment
  - **Goals:**
    - Ability to set goals; difficulty achieving them
- **Automatic Motivation**
  - **Reinforcement:**
    - good outcomes previously when complied with treatment
  - **Emotional Responses:**
    - anxiety about capability, accountability to childrens father/Health professionals; guilt if I fail; avoidance of emotions generally
- **Impulses:**
  - tendency to comfort eat when in emotional distress

Intervention

The formal formulation above was presented to Mrs J at the beginning of our second session. There were some aspects of the formulation that had been touched on towards the end of the initial assessment as it felt appropriate to do so at that time.

She reported that she found looking at the formulation useful as it allowed her to view her current situation in greater detail and with more objectivity. She also reported that while it was easy to see the areas which weren't working well (red text) it was also useful to reflect on the areas that were working (black text). She told me that this gave her confidence that change could be achieved and that she felt I had an understanding of her situation, which facilitated further development of the therapeutic relationship, initiated during the assessment appointment.

The formulation indicated that while all areas of the COM-B required addressing in order to effect the behaviour change she desired, the motivation for change was high. In terms of capability, from a knowledge and skills perspective this was also an area of strength, and these factors combined led me to believe that change may be possible in a small number of sessions, as such we scheduled 4 sessions after which time we agreed we would review the progress. Mrs J was happy with this and stated that she was encouraged with the possibility of improvements in a short space of time.

Having taken time to explore the formulation together, I proposed that over the course of our 4 sessions we would explore some psycho-education around anxiety, at a pace that Mrs J was comfortable with (see Appendix 1). This helped to promote aspects of self-management, such as preventative measures and early intervention in the form of relaxation techniques (see Appendix 2), which in turn nurtured self-efficacy (Kelly, 2008). Relaxation training has been found to be helpful in lowering "arousal" and or enhancing ones sense of control (Edgar, 1992) and as such formed an important aspect of Mrs Js management of her anxiety. Psycho-education was also employed to illustrate best practice regarding the use of medication, however, this only served to confirm that Mrs Js knowledge and skills in this area were as she had reported and required no further education.

Mrs J reported heightened anxiety, which was particularly troublesome in the morning, however she also described difficulty getting to sleep in the evening and early morning

wakening, both of which, when we explored further also appeared to be related to anxiety. This was evidenced in the HADS with an initial score of 14, falling within the clinical range for anxiety. Anxiety appeared to be an overriding factor and while the initial referral centred on her diabetes management, I felt that without addressing her anxiety fully, it was unlikely that she would be in a position psychologically to consider behaviour change. Following psycho-education, I set the task of taking 1 hour each day (worry hour) to consider the things that had caused anxiety or worry in that day. This was based on Borkovec et al. (1983) previous indications that a 30 minute period of worry resulted in a reduction of negative thoughts. This was a task that she fully embraced (See Appendix 3 for full details).

At her second appointment she brought a notepad and shared the notes she had taken. She had noted that all of her concerns had one central theme – her children and being a "good mum". This facilitated further discussion and allowed us to explore what being a "good mum" meant to her. Mrs J highlighted a number of things, some of which originated in her own childhood, while others were a result of a combined parenting style developed between her and her husband. The one thing that she was certain of was that she needed to protect her children from anything unhealthy and harmful. It was at this point that she had something of a 'lightbulb' moment – she told me that she had just realised that her girls could not be protected or have the best life if she was physically or emotionally unwell. This appeared to enhance her motivation to explore what needed to change and the task set at the end of this session was to visualise herself being a good mum, and see what might be different.

The third session saw Mrs J walk through the door with a huge smile on her face. She reported that she had maintained the worry hour and felt that this was beneficial for her. She told me that she had noticed her anxiety reducing throughout the day and that while the worry hour was not always pleasant, she felt it focused her thinking, so she prioritised the things she was worrying about. She stated that this was something that allowed her to be a good mum, she was able to give more of her time fully to her children without worrying about other things. She also reported that she was finding it easier to fall asleep and while she was sleeping for longer she still had a tendency to early morning wakening at times. We revisited the relaxation techniques to see if this would aid her falling back to sleep when she would waken early in the morning. As she was getting

ready to leave the session she stopped to tell me that she had also started taking her insulin in the evening again prior to bed, and had made this part of her bedtime routine to try and make sure she continued with it. The task to continue with following this session, was to try using one of the relaxation techniques if she woke early in the morning. At this point we also discussed how the following appointment would be our review appointment and how we might start planning for discharge at that time.

The following appointment Mrs J reported that she was continuing to use the worry hour and felt that this was something that she would likely include in her daily routine moving forward. Her sleep had improved to the point where she was waking early but able to return to sleep easily for approximately 2 hrs which she was pleased with. She had reported reinstating her evening insulin at her previous appointment and had maintained this. In terms of the goals set at the beginning of treatment she was more than happy that she had achieved these and was currently working towards a further goal – getting back into the gym. To achieve this she had asked her sister for help, to look after the kids for 2 hrs per week. She told me that she did not feel she required any further appointments at this time and I was in agreement. I assured her that while I would formally discharge her at this time, she may be re-referred in the future should she experience any further difficulties managing her diabetes.

Evaluation

As we discussed discharge, I asked Mrs J to complete the HADS again before she left. Scores indicated that she continued to be in the sub-clinical range for depression (5) while scores for anxiety indicated a shift from the clinical (14) to borderline range (8). At her fourth and final session, she reflected on the benefits achieved over the 4 sessions (8 weeks). She reported that she felt less anxious generally, as evidenced in the HADS above. She attributed this reduction in anxiety not only to consistent use of relaxation techniques, but also to being clearer in what was important for her (identification of her values). Having employed the worry hour daily for the majority of the eight weeks, she was able to identify a central value (family) from the outset. This then prompted her to examine her current lifestyle and how this was consistent or not with this core value. She reflected that the breakup in her relationship had made her feel that she had failed to live fully towards this value of providing the best for her family. As a result, while she continued to care for her children's physical and social needs she had lost faith in her

ability to provide the best for herself and her family and had neglected to care for her own physical or emotional needs. The fact that a member of her healthcare team had referred her to Health Psychology had prompted Mrs J to examine how she was looking after her own physical needs, however our sessions had expanded this further and allowed her to take a more holistic view of her current situation.

Informal feedback from the referring agent at a multi-disciplinary team meeting indicated that Mrs J had reported finding the psychology input beneficial. Recent HbA1c results indicated that blood sugar levels were more consistent, which would suggest that her medication adherence had improved as she described.

Reflections

Mrs J turned out to be the 'perfect patient'. Clinical judgement had told me that she was motivated to change which is one of the reasons that I chose this case for a case study, I believed that there would be a good solid piece of work emerge. What I did not envisage was that the work for Mrs J would be as profound as it appeared to be, in such a short space of time. She was initially referred to address poor compliance with diabetes medication, and while that issue was addressed, it almost felt as if that had been a secondary issue. I did not anticipate that this would be such a short intervention despite offering 4 sessions with review thereafter. In the last year I have started to give a set number of appointments from the outset rather than scheduling them as I go, as I feel that it is a useful way to focus the individual on the piece of work at hand and reduce the possibility of fostering a dependence. In this case, I fully expected to review at 4 sessions and then possibly offer a further 4, based on my previous experience of working with similar cases. I can only reflect that Mrs J had been contemplating change for some time, however had been unable to implement it as a result of the breakdown in her marriage and the emotional stress that caused. The fact that she was able to talk openly about her distress without judgement to someone who was independent of the situation, appeared new and potentially allowed her the space to consider what she had been through. During our sessions she reflected on how the break up had impacted on the family unit and in particular her children. She talked about the difficulty of expressing herself openly to her husband for fear of upsetting the children or impacting their relationship with their father. While this was right for the children, it had left her feeling unheard, the assessment gave her an opportunity to say some of the things that

she had been unable to for the past 3 years. I imagine that this, combined with the worry hour, which gave her a technique to releases those emotions even when on her own, was quite cathartic for her and this then facilitated the cognitive ability to consider implementing change. Bell (1982) found evidence that progressive relaxation also reduced the frequency of intrusive thoughts, this combined with the worry hour may have allowed her to move from contemplation to action.

Conclusion

In conclusion, this was an unusual intervention, but one that I took great personal satisfaction in. On another day with another individual this may be been much less successful and potentially have taken many more sessions. The fact that this individual was highly motivated, led to a level of commitment that allowed her to move forward at a pace that suited her and ultimately benefitted both her and her family. The awareness that such a profound impact was achieved not only on an individual, but a familial level led me to believe that on this occasion, I had facilitated a very important piece of work.

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Appendix 1: Psycho-education

Material developed within the Health Psychology Department at the Western Health & Social Care Trust. Not all aspects were discussed in full, however areas such as the impact of anxiety within the body and the rationale for relaxation were covered fully. The patient was given this as a handout to take home for further reading and encouraged to ask any questions that might arise at the next session.

UNDERSTANDING ANXIETY:

a self-help guide.

How/Why did I develop anxiety?

Most people find it very hard to understand just where their anxiety came from, because there is not always an obvious trigger. It is useful to note however, that anxiety is a normal state and a spur to action that we all exhibit at certain times in our life. It is when the level of anxiety exceeds normal limits in intensity, duration and appropriateness to the stimulus or situation that it becomes a problem.

Anxiety may have developed in 1 of 3 ways;

1. Through Life Strains: You may have suffered lots of minor stresses; events which may seem small, however accumulated together, they amount to quite significant stresses.
2. Specific Stressful Events: Your anxiety may have developed after a specific incident. People are more likely to suffer anxiety disorders after experiencing any of the following: bereavement, divorce, moving house, surgery, illness, violence.

3. Social Conditioning: It may be that you have 'learnt' your anxiety from a family member or friend. Sometimes when we are children we subconsciously pick up other peoples fears.

Understanding what's happening when I'm anxious!

Thoughts

e.g., What if I forget what I want to say during the presentation?

Behaviours **Physical Symptoms**

e.g., find an excuse to get out of it e.g., stomach ache, cold sweat, heart racing

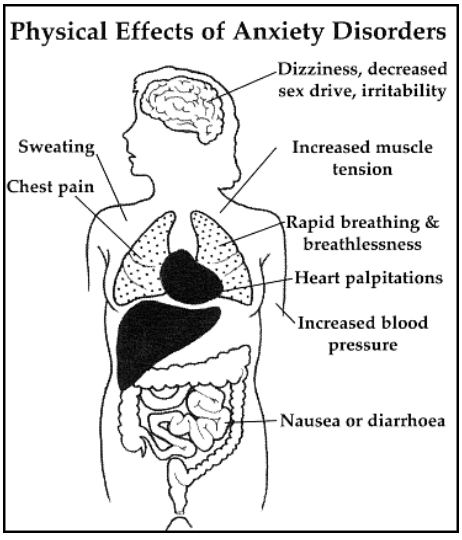
In order to understand anxiety and begin to control it, it is useful to think of it in three, distinct, but related ways:

Physical

- Psychological
- Behavioural

Physical

When you are put into an anxiety provoking situation, an automatic chain of events begins, known as the 'Fight or Flight' response. This response happens without us thinking about it because it is triggered by the part of our nervous system whose job it is to control our automatic functions (e.g.) breathing, heartbeat etc.



Psychological

At a psychological level you may experience one or maybe a number of the following thoughts and feelings when you are anxious:

- Feeling frightened and panicky
- Thinking that you might lose control and/or go mad
- Thinking that you might die
- Thinking that you might have a heart attack/be sick/faint/have a brain tumour
- Feeling that people are looking at you and observing your anxiety
- Feeling generally as if things are speeding up
- Feeling detached from your environment and the people in it
- Feeling like wanting to run away/escape from the situation
- Feeling on edge
- Clock watching

It is possible to trigger off an anxiety attack simply by thinking about anxiety symptoms. Many people make the mistake of anticipating what they will feel like in a situation before they even go. This 'anticipatory anxiety', apart from usually being much worse than the event itself, only serves to prime the body to experience 'panic'.

Behavioural

The most common behavioural symptom of anxiety is avoidance. Avoidance only serves to psychologically reinforce the message of danger, and whilst it may feel like the best thing to do at the time, it really is only a short-term solution. Some examples of avoidance are below:

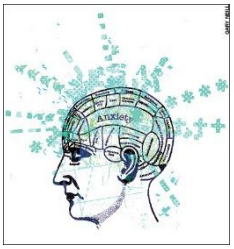
- Making excuses to avoid going out with family and friends
- Avoiding going out alone
- Rushing out of situations when you feel anxious
- Crossing the street to avoid people

If you find that you have started engaging in avoidance behaviours, don't worry, you can still help yourself. The best way to do this is to set yourself small targets that you will easily achieve, to allow you to gradually face up to the situation causing anxiety.

How do I manage anxiety?

Having discussed the three aspects of anxiety; the physical, psychological and behavioural aspects, we can look at methods of coping and how to control anxiety.

Generally, relaxation training is helpful in dealing with the physical symptoms of anxiety. Thought stopping techniques, distraction and positive thinking are useful ways of tackling the psychological symptoms, and behavioural therapy, is useful for tackling avoidance behaviour that you may have developed along the way.



Relaxation

Relaxation training is a technique that aims to reduce physical tension in the body which has built up as a result of anxiety, and involves practising specific exercises on a regular basis. There are variations on the theme of relaxation, but most centre on each muscle group of the body, alternating between tensing and relaxing. Relaxation training helps to reduce muscular tension, lower the heart rate, blood pressure and slow down the rate of breathing. If you get yourself into a state of deep relaxation before a situation that you feel will cause you anxiety, it will be harder for you to get worked up later on. The effects of deep relaxation last several hours, sometimes days!

Breathing Exercises

Many people with anxiety tend to over-breathe or hyperventilate. Correct breathing is so important in controlling anxiety. Breathing is so much more than just taking a gasp of air – with each breath, the proportions of very important gases in our blood are regulated. A change in the balance of these gases can result in you feeling light-headed, dizzy and unreal. Many people find that just by correcting their breathing, their anxiety symptoms reduce considerably. Why not try this deep breathing exercise now:

Deep Breathing Exercise

- Breathe in slowly through your nose for a count of three
- As you breathe in, push your tummy out
- Hold for a count of three
- Breathe out through your mouth for a count of five
- As you breathe out pull your tummy in

Distraction Techniques

Distraction techniques such as counting backwards from 100 in groups of three, or saying the alphabet backwards can be extremely useful in situations where you feel confined – for example in a supermarket queue, traffic jam or church. You will be surprised what you can think about when you make a positive effort to stop thinking anxiously.

Thought Stopping

Thought stopping is about stopping any anxious, unpleasant thought the moment it enters into your head. It is about learning to produce an almost automatic response to an unwanted thought. The process is as follows:

- Shout STOP loudly to yourself as soon as an anxious thought enters your head.

- Visualise a flashing red 

STOP sign appearing
- You then need to either distract yourself by using one of the techniques above, or by concentrating on something else that will *fully occupy* you.

Self-Talk

You can also learn to control anxious thoughts by talking yourself through an anxiety provoking situation. By now you should have written down all the thoughts that reoccur every time you feel anxious and so will be familiar with them. You now need to replace these thoughts with positive, rational ones. For example, if your negative thought is 'I can't cope, I'm going to have a heart attack', your response would be 'I've coped before, and now that I have learnt more coping techniques, I will do even better'. 'I know that I won't have a heart attack because it is only adrenaline that is making my heart beat faster'. 'It's a natural response to a natural bodily process.'

Finally, it's important to practice coping skills thoroughly when you are not feeling anxious, and then put them into play in the real-life situation. Also, your aim is to learn to control the anxiety, NOT to get rid of it.

Other Useful Information:

This section comprises a collection of useful information that has been gathered during years of studying anxiety and from information we have gained from anxiety sufferers.

Diet

Try to eat a sensible, balanced diet. This is important because fluctuating blood sugar levels which are a result of snacking, and not eating nutritional

meals, can produce the same symptoms of anxiety. It is advisable to cut down on instant sugar fixes, and switch to eating foods that will give you a more sustained release of sugar. Carbohydrate foods are very good at this – bread, rice, pasta etc.

Eliminate caffeine from your diet. Caffeine increases anxiety symptoms, particularly palpitations, feeling jumpy, and shakiness. Caffeine whilst being present in coffee, is also found in tea, chocolate, and Coca-Cola.

Cut down your alcohol intake. Excess alcohol can make you more prone to the effects of stress.

Cut down on smoking or stop completely. Nicotine and other chemicals found in cigarettes actually increase symptoms of anxiety by increasing the heart rate and blood pressure.

Physical Exercise

There is no getting away from the fact that physical exercise as well as being great at keeping us healthy, also keeps us mentally well. Exercise causes release of the body's natural endorphins. Any exercise then will help to lower your stress levels, and therefore help to control anxiety.

Anxiety and Depression

It is useful to note that depression and anxiety commonly occur together. Not everybody who is anxious is depressed, but most depressed patients have some symptoms of anxiety. The fortunate thing however is that receiving treatment for depression should also have a positive impact on your symptoms of anxiety.

Appendix 2: Relaxation Techniques

Relaxation techniques explored:

1. Diaphragmatic Breathing
2. Progressive Muscle Relaxation (PMR)
3. Self-Hypnosis Relaxation Script

Appendix 3: Intervention Details

Session 1: Sharing and discussion of the formulation. Reflection on areas of strength and weakness. Motivational interviewing utilised to explore the problem behaviour/behaviours further. Space allowed for story telling which gave context to when the behaviour changed and the emotional state at the time, establishing the antecedents of the behaviour. Psychoeducation (see appendix 1) on anxiety, the best practice regarding the use of medication, and basic relaxation techniques was employed. This allowed both Mrs J and I to identify what areas required attention, for example, knowledge and skills regarding the use of medication in diabetes was high, however this did not translate into practice. We reflected that Mrs J possessed the capability, opportunity and motivation for behaviour change and spent some time questioning why this then did not translate into practice. This allowed her to identify an anxiety was potentially preventing the implementation of behaviour change. This is something that I felt it was important to continue working on between sessions and as such I set the Mrs J the task of employing a worry hour daily. She was instructed that she was allowed to worry for 1 hour each day. This meant that for the other 23 hours of the day, anything that popped into her mind that caused concern or worry needed to be 'put on hold' until the worry hour, when it would be explored fully if she wished. Guidance about how she might use the worry hour was given, she was to set aside an hour where she would not be disturbed and focus on the various issues that had cropped up throughout the past 24 hours that had caused her concern. She could choose to focus on all of the issues individually or one or two particular issues. If she was happy to keep a notebook/diary and write down her thoughts and feelings that would be useful, alternatively if she preferred to sketch/draw and felt that would assist her in that was also ok. She was also given the option to keep this simply a mental exercise if she felt more comfortable with that approach. The only firm guideline was that she should set a timer and once the hour was

over, she needed to stop and do something completely different, putting any further worries on hold until the next days worry hour. We agreed that we would revisit this at our next session and assess how useful or not it had been.

Session 2: At the second session I observed Mrs J entering the room in what can only be described as an excited manner. On the previous two occasions, she appeared timid, almost reticent to enter the room, today she seemed eager. She was talkative from the outset and quickly produced a notepad that she had been using to record what she had been exploring in her worry hour. She retained ownership of the notepad at all times. Having used the worry hour before, I have seen patients come into session and produce sheets of paper with notes, almost like handing over homework to the teacher. Mrs J retained her notepad and shared aspects of it with me. It was impressive on a number on counts, she had obviously been using the worry hour daily going by the number of entries. Her style was to record everything in spider diagrams, she had used coloured pens, identified sub-themes but had linked everything back to one central theme – her children and the need to protect them. We spent some time discussing this, using some of the items she had recorded in her notebook to explore further and I queried how her diabetes factored here as I hadn't noticed it recorded anywhere in her spider diagrams. She stopped talking and took a few minutes before she looked at me again and reflected that she would be unable to protect her children if she was unwell so her diabetes was a big factor that seemed to have gotten "lost" in everything else that was going on. We re-examined the best practice use of her prescribed diabetes medication and what she was actually doing. Mrs J identified one particular time of the day that seemed to often be neglected in terms of taking medication, this then impacted everything else. As we were approaching the end of the session I suggested we revisit the relaxation strategy employed in the previous session, progressive muscle relaxation, and progress it using some

imagery around what life might be like if she was taking all medication as prescribed and being a "good mum". I also asked her to continue with the worry hour as well as the imagery between sessions.

Session 3: This session saw Mrs J enter the room with a smile, again appearing eager to attend. She reported that she had continued to use the worry hour daily and felt that this was something she would continue to do going forward. I enquired about what it was that she felt was useful about it and she reported that she no longer felt anxious throughout the day. She remarked that while she hadn't realised it before, she woke each morning and felt anxious as she thought about what needed to be done that day and that stayed with her throughout the day. What she discovered using the worry hour was that this had stopped, it had been a forced thing initially – stopping the worrying thoughts until her worry hour, however she felt she was now more practiced at this to the point where she did it automatically. Things that would have made her anxious before, now had to wait until the worry hour. This had given her great portions of the day without worry, which she told me allowed her to be more productive in her tasks of daily living which in turn reduced frustration. She had also noticed improvements in her sleeping pattern which gave her more energy for the day ahead. When I reflected that it must make for a very 'busy' worry hour, she laughed and told me that while that had been her concern at the outset the reality was very different. She remarked that the small things that she assigned to her worry hour each day rarely got addressed, but that was ok, she had deducted from that that those small worries, were likely unimportant if they didn't factor in the worry hour. In this regard she felt that the worry hour had helped her focus and prioritise the things that she worried about. She also told me that she had started taking all her prescribed diabetes medication exactly as prescribed and had developed a routine around this to ensure habit formation. This is something that we had discussed at the last appointment when we had identified that she often missed one

particular time to take her medication. She had become aware that the other times she did take her medication coincided with a daily routine and so were less likely to be forgotten about. So she had taken this knowledge and used it to help ensure that a similar approach was taken at all times medication was required. We discussed potential discharge at the next appointment if the progress achieved to date was sustained and this was something that she appeared happy with.

Session 4: Mrs J attended on time, as always, and appeared relaxed and confident. While the previous three appointments had been in fortnightly intervals, this final appointment had been approximately 4 weeks since her previous appointment. This had been the result of a holiday period, but was useful in that it gave her the opportunity to have a longer break between sessions to identify any potential difficulties as we approached discharge. She reported that she had enjoyed the holiday period with her children and with her family of origin when the children had been with their dad. She reflected that on previous holiday occasions when her children had spent time with their dad, she would have tended to withdraw into herself, spend time alone at home and worry about how her children were doing without her. She told me that she continued to use the worry hour and found this beneficial. She also reported that she continued to use the relaxation strategies practised in session at least a few times during the week and felt that this was part of a new routine that she had established and would maintain. Her diabetes had remained stable over the holiday period, and while she had focused on good dietary intake, she had also adhered to her full medication regime and felt that this was now well established and unlikely to change. She had also set a further goal of getting some additional physical activity incorporated into her lifestyle to further address her diabetes management. She had a number of factors in place to support this goal and felt that it was achievable as a result. We discussed relapse prevention and she had been actively planning how she would prevent this initially, but also address it should it become an issue. As the initial goal of addressing her

diabetes management had been achieved and was currently being built upon it was felt that no further intervention was required at this time. We agreed to discharge and she was fully informed of how she might access services in the future should the need arise.

Appendix 4: Behaviour Change Techniques Employed

Taken from (Dixon, 2010)

Motivation Development Techniques		
BCT Code	**Name of BCT**	**Intensity Level**
M20	Reassurance	Low
M17	General Information	
M12	Social Support (emotional)	
M10	Information about the behaviour	
M11	Verbal Persuasion	
M1	Antecedents & consequences	Medium
M13	Decision Making	
M15	Motivational Interviewing	
M21	Reframing	
M2	Comparison	
M7	Anticipated Regret	High
M14	Coping Strategies	
M18	Assertion Training	

Action on Motivation Techniques		
BCT Code	**Name of BCT**	**Intensity Level**
A3	Self Monitoring of Behaviour	Low
A1	Goal Setting	
A12	Instruction	
A9	Coping Planning	
A8	Action Planning	
A10	Goal Review	
A4	Antecedents & consequences	Medium
A2	Standard	
A5	Feedback	
A15	Self Talk	
A18	Relaxation	
A20	Homework	
A22	General Problem Solving	
A11	Graded Tasks	
A13	Behavioural Rehearsal	High
A16	Imagery	
A17	Relapse Prevention	
A30	Assertion Training	

Prompted or cued route		
BCT Code	**Name of BCT**	**Intensity Level**
P15	Modelling	Low
P2	Prompt	
P3	Contingent Reward	Medium

P8	Graded Tasks	
P9	Shaping	High
P10	Chaining	
P11	Behavioural Rehearsal	
P12	Mental Rehearsal	
P13	Habit Formation	
P17	Imagery	
P31	Habit Reversal	
P47	Stimulus Generalisation	
P38	Stress Inoculation Program	

Case Study 2

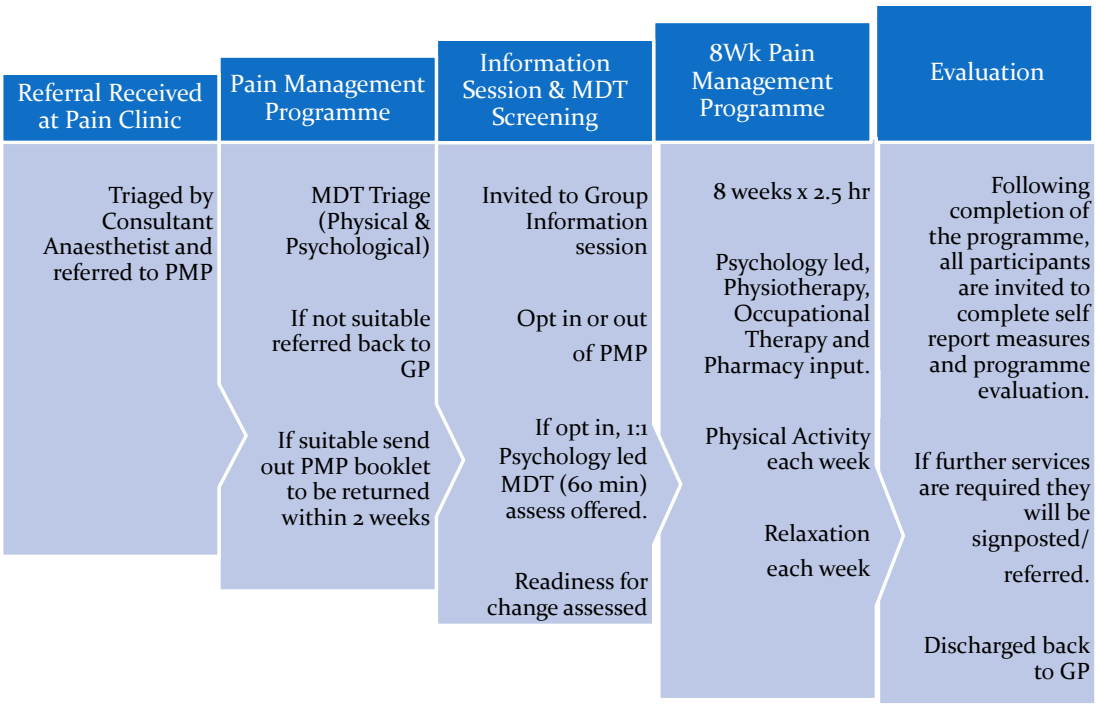
Introduction & Context

This case study outlines my role in the development, delivery and evaluation of the Psychology led, multidisciplinary pain management programme in early 2020. Due to the wide geographical spread of this Trust, two PMPs run concurrently with the Specialist Clinical Psychologist running the programme on one site while I take the lead (with supervision) on the other site. This programme has been driven by the psychology team within the trust, in partnership with the pain clinic for 10+ years. My role in formulation of this specific PMP is highlighted in the formulation section below.

Referral Information

The Pain Management Programme (PMP) is a psychology led, multi-disciplinary (MDT) programme, comprised of Specialist Clinical Psychologist, Trainee Health Psychologist, Physiotherapist and Occupational Therapist, employed in the management of chronic/persistent pain - pain which persists beyond normal healing time (Bonica, 1953).

Figure 1. *PMP Format*



Presentation

Eighteen individuals were invited to attend an information session for the pain management programme. An 83% response rate was achieved with 15 of the 18 patients attending the information session. All 15 opted to proceed with attendance at PMP and were offered appointments for face-to-face (FtF), joint assessment with myself, the physiotherapist and occupational therapist.

Assessment

Assessments are conducted at the site where the individual is likely to attend the programme; as a result the Specialist Clinical Psychologist manages one site while the I run the programme on the other site. The assessments are psychology led, and key contributions from the other professionals inform these.

The multidisciplinary PMP assessment follows a biopsychosocial model developed by Engel (1977), and allows us to identify a range of factors that may contribute to an individual's overall physical and psychological health. Bishop (2005, p.219), highlighted that "the onset of a chronic illness is a life-changing event, signifying the beginning of a lifetime process of adapting to major physical, psychological, social and environmental changes", and it is important that as a clinician involved in an individual's care I have an understanding of this experience.

I conducted formal individual assessments, supported by the occupational therapist and physiotherapist, with each of the 15 patients, taking the format of an hourlong, semi-structured clinical interview. I informed the individuals about the nature of the service, what it could offer, the limits of confidentiality, my role as a health psychologist in training, as well as the potential for onward referral. Once all queries had been addressed the client was asked to sign a consent form indicating that they a) understood the information given to them and were happy to proceed; b) Consented to us checking their Electronic Care Record if further clarification was required, and c) Consent to anonymised data from outcome measures being used for the purpose of research/audit/service development.

Given the physical impact/limitations of chronic pain, I have found that it is often useful to begin the assessment by exploring this aspect first, as it allows the individual to impart information that is familiar and safe. As a trainee health psychologist, I feel it is important to be aware of the types of medical procedures and investigations that may

be carried out within the speciality you are working in. Knowledge of information gained from biological assessment methods conducted by other health professionals is essential in understanding what the individual has experienced to date. Not only does it inform the assessment, but it enhances the engagement of the individual and often allows a platform from which the psychological and social/environmental factors can then be explored naturally. To supplement the clinical assessment, condition-specific empirically supported tools were employed and provided a succinct way of capturing a range of information, which can be used to inform and tailor the intervention.

Table 1: Self-report measures employed

Measure	**Scale Ranges**
Brief Pain Inventory (BPI) *(Cleeland, 1994)*	Pain Severity Score 0-10 Pain Intensity Score 0-10
Hospital Anxiety & Depression Scale *(Zigmond and Snaith, 1983)*	Anxiety 0 - 21 Depression 0 – 21 0-7 normal 8-10 borderline 11-14 moderate 15-21 severe
Pain Self Efficacy Questionnaire 2 – Short Form *(Nicholas, 2015)*	Pain Self Efficacy 0-12
Pain Health Questionnaire-4 *(Kroenke et al., 2009)*	Psychological distress ranges from 0 to 12 None 0-2 Mild 3-5 Mod 6-8 Sev 9-12

As a result of the assessments, I felt that onward referral to mental health services was more appropriate for one individual, while 14 were accepted as suitable for PMP and offered a place on the next available face to face programme.

Medical History

Patient Characteristics are presented in Table 2. Detailed medical histories of those assessed are not outlined here, however it is important to note that 93% of the patients presented with one or more comorbid physical conditions (e.g., asthma, endometriosis & irritable bowel syndrome), with 100% presenting with one or more comorbid mental health (e.g., anxiety & depression) conditions. While the focus of the PMP is to help individuals discover alternative strategies to manage their pain, treatment can be complicated by medical co-morbidities, polypharmacy, and psychiatric co-morbidities to

name a few (Peppin, Marcum and Kirsh, 2014). A thorough clinical assessment is therefore crucial in delivering an evidence-based group programme, while at the same time tailoring the content to the needs of that particular group of individuals. While this is a programme that runs regularly and utilises similar information as its basis, the participants, as well as the complement of staff delivering the group, make it a unique experience each time. My role in this programme is to identify, through the assessment and formulation, the key areas where tailored intervention is indicated for each individual, and to deliver and evaluate that intervention.

Table 2. *Patient Characteristics*

Descriptive Statistics	Duration of Pain yrs [range]	Age [range]	Gender	Work Status	Primary Cause of Pain
Suitable & Invited to PMP (n=14)	8.6 [1 - 30]	47 [29 – 69]	12 females (86%), 2 males (14%)	7 unemployed 3 FT employment 2 retired 2 med retired	9 Fibromyalgia 2 Injury 1 Cauda Equina 1 Rheumatoid Arthritis 1 Unexplained
Following 1st PMP Session (n=9)	7.7 [1 – 30]	47 [29 – 69]	9 females (89%0, 1 male (11%)	4 unemployed 3 FT employment 2 retired	6 Fibromyalgia 1 Injury 1 Cauda Equina 1 Unexplained

Formulation

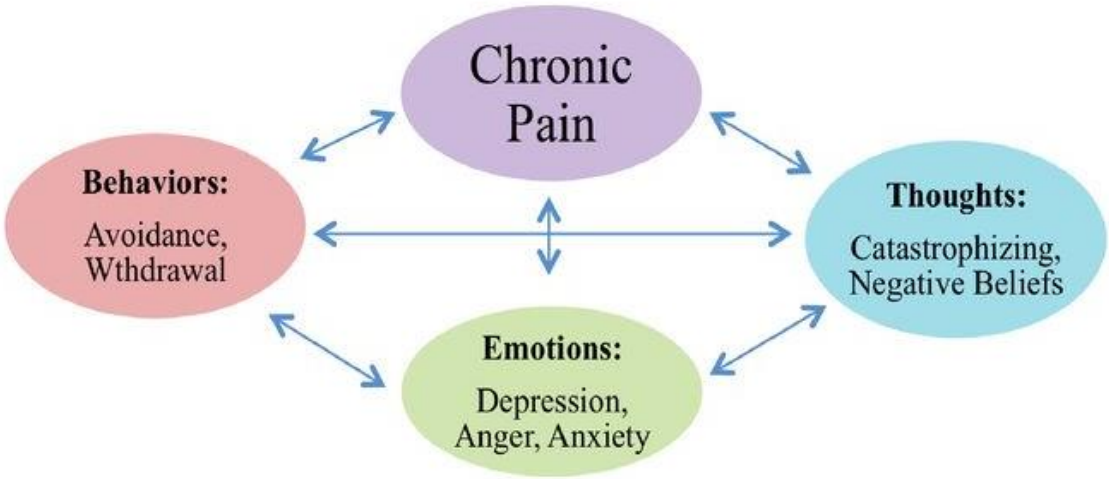
The assessment provided a large amount of complex, yet clinically relevant information, which I used to develop a formulation which informed all aspects of the intervention. In this case a broad range of psychosocial factors were considered, alongside the patient characteristics detailed in Table 2. There were several other factors that were important to consider such as their support systems, number and age of dependants, as well as other life experiences that can impact psychologically. For example, in this group, one participant was experiencing ongoing distress following a family disagreement, three were highly educated individuals with a strong theoretical understanding of chronic pain, yet struggled to integrate this to their pain management plan, and another individual had experienced a number of significant losses to suicide in recent years. While some of this information may seem unrelated to the formulation of a pain

management programme, without taking it into account and tailoring the programme around it, I would be unable to develop a meaningful and worthwhile intervention for those involved.

The British Pain Society (2013) guidelines for pain management programmes (currently under review) have shaped the way in which many PMPs have been designed and delivered. The evidence for the efficacy of Cognitive Behavioural PMPs in improving pain experience, mood, coping and negative outlook on pain and activity levels has been good and widely documented (Williams, 2002a). In recent years, however, there has been a shift towards adopting a more Acceptance and Commitment Therapy (ACT) approach to managing pain (Casey et al., 2020) and while the PMP I have developed is certainly rooted in CBT, I feel that my delivery has developed to encompass aspects of ACT (explored below).

A cognitive behavioural formulation of pain considers the relationship between thoughts, feelings, behaviours and chronic pain (See Figure 1 below).

Figure 2. *CBT Formulation of pain*



This formulation was introduced to the group on the first session and allowed me to engage the members of the group as active participants in their pain management at this early stage. Considering the bio-psychosocial factors described by each individual in the group, I explored, using the formulation, ways in which the cycle of chronic pain

could be disrupted. For some this was about addressing thinking patterns, using cognitive restructuring or cognitive defusion, for others it was exploring ways of re-engaging them in previously enjoyable activities using behavioural activation, identifying values, goal setting and pacing. As mentioned above, there has been a move towards a more ACT approach to managing chronic pain in recent years. ACT is described as a 'third wave' therapy, evolving and extending from CBT and as such I find that the many of the core therapeutic principles, namely; acceptance, cognitive defusion, values and committed action, naturally complement the CBT formulation described above and implement these to support the CBT formulation.

Intervention

The British Pain Society (2013, p.8) recommends pain management programmes, based on cognitive behavioural principles as "...the treatment of choice for people with persistent pain which adversely affects their quality of life and where there is no significant impact on physical, psychological and social function". These recommendations enabled me to develop a set of *PowerPoint* presentations that were based on cognitive behavioural principles and addressed issues common to the patients I had encountered who struggled with persistent pain (see Appendix C).

Fourteen participants; 2 male and 12 female, ranging in age from 29 – 69 years of age, were invited to attend the eight-week programme, beginning on 4th February 2020. The introductory session of the PMP (ftf) began with 10 participants, 1 cancelled as a result of ill health, 3 Did Not Attend and 1 lady arrived approximately 45minutes into the 2.5hr session. The physiotherapist and occupational therapist were also present at this introductory session. The lady who joined late appeared confused and distracted throughout; when I spoke with her individually at the end of the session she reported that she found the group difficult and attributed this to the numerous viewpoints presented by others.

I consulted with the other members of the team about how we should proceed. I highlighted earlier concerns I had regarding her cognitive ability as well as her reports of struggling to follow the information presented in the introductory session. I felt that despite PMP information being useful for her, the group nature of the programme was challenging. However, I also felt a duty of care to provide some pain management input for this lady as had been agreed. Following further discussion with my clinical

supervisor, I proposed that I would offer 4 individual appointments to cover the psychological component of PMP and my supervisor agreed that this was appropriate. As a result, in the first week of PMP the group reduced from 14 to 9 participants (1male and 8 females).

Appendix C includes a list of all topics covered each week, details of the intervention specific to this group, and copies of the psychology talks I have developed over time and *PowerPoint* slides to support these. While I cover these talks regularly within PMPs, they merely form a framework for the information explored within each group. My role is to guide the participants in exploring this tailored information at a pace and depth that is comfortable yet challenges them enough to consider their role in managing their pain. This can be a 'balancing act', and each group is distinctly tailored as a result. When I reflect on my early delivery of PMP, I am acutely aware of the anxiety this induced in me – the uncertainty of what a new group might present. I feel guilty when I think about how my delivery then, differs from my delivery now, and was more a presentation of the information on the slides in those early days. With experience and becoming familiar with this patient group and the challenges they encounter, my delivery now is vastly different, and I look forward to each group and the challenges it brings. I feel this highlights a personal shift in my moving from working at low intensity practice to high intensity practice in recent years (Dixon, 2010).

Pain management programmes employ a large degree of psycho-education in the early stages of a programme. Gate Control Theory of pain (Melzack and Wall, 1965) is utilised within the programme to illustrate how a cognitive behavioural (CBT) approach might be useful in the management of chronic pain (Williams, 2002b). The early stages of PMP involve a number or low-medium intensity behaviour change techniques, detailed in Appendix D. These all help to engage the participants, many of whom have been dealing with pain in one way (medication) for many years. PMPs aim to see participants more involved in daily activities that they enjoy and therefore enhance their quality of life (BPS, 2013), rather than identify or cure their pain. Therefore it is important at the beginning to help participants understand this different approach and the rationale for it. The psycho-education component, while important, is only the starting point, however allows the participants to build relationships with both healthcare professionals and each other. This provides a safe platform from which they can then be

guided to explore their own role in managing their pain. Behaviour change techniques (as shown in Table 3) employed throughout the programme across all intensity levels. These are listed in further detail Appendix D

***Table3**. Behaviour Change Techniques utlised. (Dixon, 2010)*

	Topic	Professional	Behaviour Change Technique (route to behaviour change)		
			M	**A**	**P**
1	Welcome and Intro Ice Breaker Intro to Exercise	Psychologist Psychologist Physiotherapist	Reassurance, General Information, Social Support, Verbal Persuasion	Instruction	
2	Stress Management Exercise Relaxation	Psychologist Physiotherapist Psychologist	Information about the behaviour, Reframing, Coping Strategies, Assertion Training	Instruction, Coping Planning, Self-talk, Relaxation, Homework, Behavioural rehearsal	Shaping, Habit formation, Stimulus generalisation, Stress Inoculation programme
3	Values Goals & Guiding Change Exercise/Relaxation	Psychologist Occ Therapist Physiotherapist	Reassurance, Information about the behaviour, Antecedents & Consequences, Decision making, Motivational Interviewing, Comparison, Reframing	Self-monitoring of behaviour, Goal setting, Action planning, Standard, Feedback, Self-talk, Homework, General Problem solving, Graded Tasks, Relapse Prevention, Assertion Training	Modelling, Contingent Reward, Shaping
4	Pain Pathways Exercise Relaxation	Physiotherapist Physiotherapist Psychologist		Goal setting, Goal Review, Relaxation, Behavioural Rehearsal	Prompt, Habit Formation, Stimulus generalisation
5	Managing Mood Exercise Relaxation	Psychologist Physiotherapist Psychologist	Antecedents & Consequences, Decision making, Motivational Interviewing, Coping Strategies	Coping Planning, Goal Review, Self-talk, Relaxation, Homework, Behavioural Rehearsal, Imagery, Assertion Training	Prompt, Shaping, Mental Rehearsal, Habit formation, Stimulus generalisation, Stress Inoculation programme

6	Pacing (Boom/Bust) Sleep Exercise/Relaxation	Psychologist Psychologist Physio/Psychologist	Reassurance, Information about the behaviour, Decision making, Motivational Interviewing	Goal Review, Antecedents and consequences, Feedback, Homework, General Problem solving, Graded Tasks, Relapse Prevention, Assertion Training	Modelling, Prompt, Shaping, Mental Rehearsal
7	Medication Management	Pharmacist Input		Goal Review	
8	Flare Ups Exercise Relaxation	Physiotherapist Physiotherapist Psychologist		Goal Review, Relaxation, Imagery, Behavioural Rehearsal	Habit Formation, Stimulus generalisation

It would be easy to assume from the details above that PMP is a manualised programme, however, what is actually delivered is a programme rooted in evidence-based practice which is tailored to the group each time. This is one of the reasons it provoked so much anxiety in me when I initially started delivering it, however, it's also the reason I look forward to it now. It is also why a thorough psychological assessment from the outset is essential. In this group 100% of the participants had at least one comorbid mental health condition, however, 33% of those reported significant trauma symptomology and as such I ensured that both assertion training and stress innoculation were specifically included in this programme to offer additional strategies for these patients.

Early last year a new physiotherapist joined the MDT. She previously delivered the physiotherapy-led 'Moving with Pain Programme'. The basic educational elements are similar to PMP, however, she reported being overwhelmed at the level of psychological detail PMP explored and utilised throughout PMP. I found her reflections a revelation. Having delivered PMP interventions for some time, I feel I neglected to appreciate the centrality of my role in this programme. This was again was highlighted when I was unable to take annual leave unless I could get another psychologist, familiar with PMP, to cover my session. Both incidences highlighted the centrality of my role in the programme, something which I had neglected to fully appreciate until recently. I believe that this lack of awareness resulted from effective MDT working as well as a measure of complacency on my part.

While this group started as a face-to-face (FtF) group programme, unfortunately, as a result of COVID 19 we had to switch from FtF, group delivery to individual, telephone delivery after week 5, as all clinical activity had been suspended to reduce the spread of COVID 19. This had a significant impact on the programme. As a result of sheilding the occupational therapist was unavailable, to add to this the physiotherapist for the programme was being considered for redeployment within the community and therefore was uncertain of how much she would be able to input. I initially made contact with all participants of the programme and explained the changes we needed to make.

Eight of the nine patients opted to complete the programme individually via telephone while one opted to wait until FtF, group programmes were resumed. While this changed the nature of the programme thankfully I was able to deliver most psychological aspects of the programme, albeit in a different format.

Evaluation

As stated in the assessment, the clinical interview was supplemented by self-report measures, namely, HADS (Zigmond, 1983), BPI (Cleeland, 1994), PSEQ-2 (Nicholas, 2015) and PHQ-4 (Kroenke, 2009). These self-report outcome measures were employed again at the end of the programme and allowed me to identify and quantify the range of improvements that PMP facilitated. Table 2 below details the scores obtained pre and post PMP.

***Table 4**: Outcome Scores*

	BPI Severity		BPI Intensity		HADS Anx		HADS Dep		PSEQ-2		PHQ-4	
	Pre	**Post**	**Pre**	**Post**	**Pre**	**Post**	**Pre**	**Post**	**Pre**	**Post**	**Pre**	**Post**
1	6.75	8.75	9.9	10	17	14	19	18	2	0	12	12
2	7.25	6.75	7.6	6.3	18	13	14	14	4	4	10	12
3	4.25	4.25	7.7	7	14	12	9	9	4	6	7	6
4	5.25	4.75	7	6.3	16	13	17	16	10	11	12	9
5	9.25	9.75	9.1	8.8	19	18	14	16	6	6	12	11
6	5.75	5.25	6.6	6.6	16	16	17	15	2	6	7	6
7	5.25	5	5.4	5.4								
8	9	8.25	8.4	8.2	13	11	16	13	7	6	12	10

As table 4 shows, scores obtained in the Brief Pain Inventory (BPI) show little improvement with some scores for pain severity and intensity increasing. Although there was some improvement in scores this was minor for most, with 2 reporting increased pain severity and intensity, 3 staying the same and 3 improving marginally. Mood related scores show marginal improvements, except in one case where it remained the same. This is an issue that I, as a trainee health psychologist delivering a behavioural change intervention have struggled with. Senior managers and commissioners rely on quantitative data to illustrate how effective a service is, unfortunately in pain management this is not always appropriate. For many patients, scores on outcome measures may not reflect significant change, however, observationally significant improvements in how they manage their pain can be seen and is often supported in their self-report. As a result, all participants are asked to complete a programme evaluation exploring their experience of the group, the facilities,

the level of information, length of programme etc (see Appendix 5). This evaluation allows for qualitative feedback, which often gives greater insight into the impact of PMP and allows an evaluation of delivery. Some feedback from this programme is highlighted below:

We asked 'Which Part of the group did you find most useful'?

> *"The actual group setting was fantastic. Sharing Stories. I was nervous to begin with but it definitely works."*
>
> *"Understanding of pain – the fact that there is no pain centre in the brain. Pacing. Management of Stress. Goal Setting.*
>
> *"I couldn't really pick one part as I really enjoyed the full course."*

Reflections

There were several aspects of this group that were challenging. The group nature of this work I find extremely enjoyable, however, each group is different in its own respect as a result of their needs and the unique personalities involved and how they work together. This group started out with four very strong personalities, with one who was very invested in the medical model. I was apprehensive as we began this programme, wondering if the group of individuals chosen were a good fit. On that first morning I really doubted how this group would come together and provide a safe space for each other to explore the difficult issue of chronic pain, this was compounded when I realised that one participant was not suitable for the group approach. With a group comprising of strong personalities, unbalanced in terms of gender, pronounced pain behaviours and a participant not actually suitable for a group approach, I felt that I had somehow missed something in my assessments. Drawing on experience of previous groups I was able to reassure myself that many of the first days of PMP start like this, and often have me doubting myself. Having arranged a treatment plan for the participant not suitable for the group and moving into week 2 I started to feel more comfortable, which inevitably had a positive impact on my engagement with participants.

The impact of COVID-19 and having to change the intervention was another challenge. As a result of the restrictions imposed due to the pandemic, contact had to switch to 1:1

telephone contact rather than FtF after the first 5 sessions. This impacted on the programme in that it created a physical break; we normally try to minimise any breaks in delivery in the 8-week programme, as this can hamper engagement. The staffing complement had also reduced and meant me and other members of the team had to think of how we might do things differently. The change of delivery from group, FtF contact to 1:1 telephone contact was something that I struggled with, as I now realise that I tend to rely on visual observation of how participants receive/react to information. While individual telephone contact appeared to work, it was reflected on in the evaluation, "the group setting was fantastic". I am aware that the group format is useful in helping to normalise the experience of pain and unfortunately in this instance we were unable to facilitate this. The form of delivery (FoD) is a key 'active ingredient' in behaviour change interventions (Dombrowski, 2016), and it was my concern that with the change in FoD with this group, the therapeutic alliance may be compromised. Thankfully this didn't appear to be the case for most of the group and I can only speculate, given the nature of their engagement in telephone contact, that having met them all on five previous occasions, a strong therapeutic relationship had been established and was able to be maintained virtually.

I am unsure if anything could have prepared me for the impact of COVID 19, particularly in the delivery of a group programme, however, having since delivered this programme in two different formats; telephone and online, I believe that I have become more open to alternatives for future programmes. I encourage psychological flexibility in my patients, however I had possibly become a little 'stuck' and inflexible with how I had been delivering these type of programmes, and this experience has definitely made me more open to alternative forms of delivery.

Conclusion

As highlighted in Eccleston et al. (2020) for those in chronic pain, if denied assessment and treatment, their condition does not stay as is but can "worsen significantly". Therefore, it is important when faced with challenges to the normal delivery of services that we become more creative and embrace alternative methods of delivering treatment. In this case, the alternative was to move to telephone contact. While this may not have been ideal and is likely not how I would continue to deliver this service, it allowed the needs of this group to be met at that time. Recent feedback suggests that

telephone delivery worked for these participants. They highlighted the lack of travel to appointments, thus reducing the financial investment, as well as reducing their stress battling through traffic or finding parking. The cost implications for the Trust were also reduced as staff were able to provide contacts from their base rather than having to travel to other sites.

While telephone or online programmes (I have since moved to this form of delivery) provide an opportunity to avoid 'missed care', and an opportunity to reach individuals who may struggle to physically travel to programmes, we must be mindful that it is only one of a range of options. Telephone or online contact will be suitable for many, however, there will also be others who either require or prefer face to face contact. However, the challenge posed by COVID 19, allowed me as a health professional to do what I ask participants of PMP to do – step outside of the comfort zone and embrace a different way of working, thereby reminding me of just how challenging that can be.

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Appendix A: Pain Management Referral Form

Pain Management Program Referral Form

(Please include a copy of your GP letter with the referral)

Date of Referral: Hospital No: H&C No:

Patient Name:

Address:

Postcode:

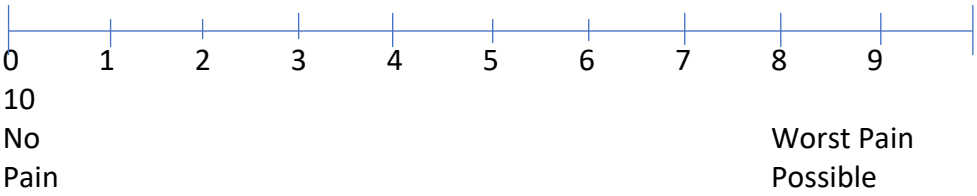
Date of Birth: Telephone No:

Referrer:

Contact No:

Presenting Problem and Reason for Referral:

Please indicate the patients reported pain level currently:



Treatment	Yes	No
All medical interventions are completed.		
There has been a clear conversation regarding the chronic nature of pain and that there is no curative treatment at present.		
Patient's distress is primarily from their pain.		
Readiness		
Patient is keen to move towards self-management.		
Patient is ready and capable of attending a group based intervention.		
Consent		
Patient has agreed to the referral.		

Other exclusion		
The patient has current addiction problems.		
The patient has unstable mental health problems including active suicidal ideation.		
The patient has a cognitive deficit that may preclude a group based intervention.		

Guidelines for referring patients to the Chronic Pain Management Service

Contact Details:

The Pain Management Programme

[redacted]

Referral Criteria:

Prior to referral: please ensure that the following conditions have been appropriately managed:

- All patients displaying 'red flags' signs or symptoms should be referred to the appropriate speciality for investigation/treatment as a matter of urgency
- Patients with radicular arm or leg pain should initially be referred to the spinal surgeons
- Patients with mechanical spinal pain should have undergone a course of physiotherapy, and have received an adequate trial of analgesia
- Patients with neuropathic pain, pins and needles and formication should have received an adequate course of analgesia and commenced a trial of anti-neuropathic pain medication
- Patients with pelvic pain should have undergone investigation by members of the appropriate gynaecological/urological specialities.

Exclusion Criteria:

- Pain problems where treatable pathology has been inadequately assessed and excluded
- Severe unstable psychiatric illness

For patients with chronic pain, which has been persistent for a minimum period of 12 weeks, we will accept referrals on the referral proforma, together with the patients GP letter, provided:

- The above guidance has been followed
- Where possible, a diagnosis has been made
- The patient has not been referred to another speciality for the same problem
- Where there is significant or increasing disability or distress due to chronic pain
- The patient has poor self-management leading to excessive demands on primary health care services.

PAIN MANAGEMENT PROGRAMME

PRE-ASSESSMENT BOOKLET

Pain Management Programme
What You May Need to Know

Multidisciplinary Team Consisting of:

Team Lead Consultant in Pain Management

Physiotherapist

Specialist Clinical Psychologist

Trainee Health Psychologist

Pain Nurse Specialist

Occupational Therapist

Pain Management Programme

Pain management programme (PMP) looks at the effects of chronic pain on the individual's physical and psychological wellbeing, and its impact on their day to day living.

The programme consists of:

- education on pain psychology,
- information on how pain is communicated in our bodies
- maintenance of healthy physical function
- self-management strategies relevant to pain
- pacing and setting goals which are relevant to the individual
- identifying and challenging negative thinking, unhelpful beliefs and habits which can contribute to pain and reduced function
- relaxation techniques / energy conservation / exercise protocol
- **The overall goal is to reduce the physical limitations and emotional stress caused by chronic pain.**
  The programme is delivered in a patient group setting either face to face or virtually by a team of health care professionals.

The PMP aims to increase your confidence and skills in managing your pain, and may reduce your pain.

When attending the Pain Management Programme, your success will depend on:

- Committing to regular attendance at every session.
- Looking at pain in a solution focused way.
- Being open-minded and participating to the best of your ability.

Completion of this Booklet

Before you attend the Pain Management Programme it is important for the staff to have some knowledge and understanding of how your pain is impacting on your day to day activities. Once the booklet is returned to the Pain clinic you will be invited to attend an information session.

If you experience any difficulty in completing this booklet, staff can assist you when you attend for the information session.

If you feel that the pain management programme is not right for you at this time, please call us so that we can discuss your individual treatment plan.

Consent to Attending Pain Management Programme ☐

Consent to medical records being checked if any further information required. ☐

Consent to anonymised data being used for service development. ☐

Consent to receiving information via email ☐

Name _____

Address _____ Date of Birth _____

_____

_____

Post Code _____

Home Tel. No. _____Mobile Tel. No_____

Email Address:_____

_____

Next of Kin Name and relationship :

_____

Next of Kin Contact Number:

_____

GP _____

Surgery/Health Centre _____

Referring Consultant/GP _____

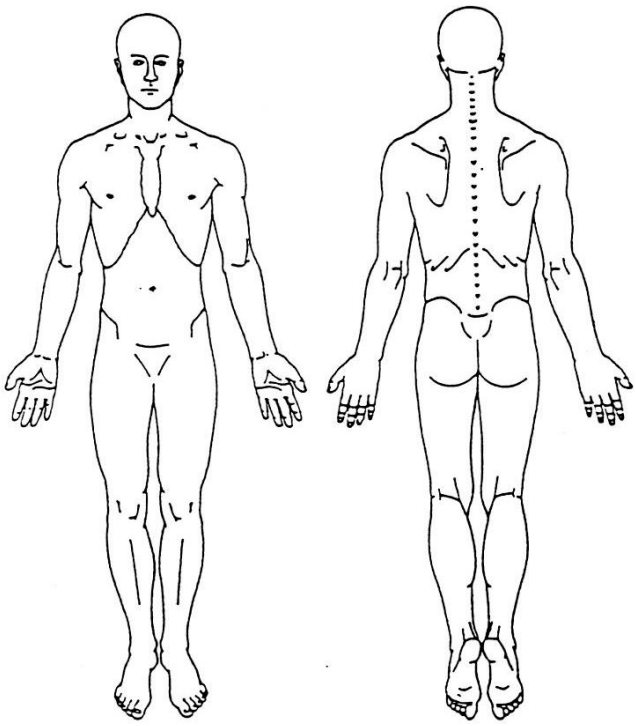
Patient Signature: _____ Date: _____

Brief Pain Inventory (Short Form)

1. Throughout our lives, most of us have had pain from time to time (such as minor headaches, sprains, and toothaches). Have you had pain other than these every-day kinds of pain today?

Yes **No**

2. **On the diagram, shade in the areas where you feel pain. Put an X on the area that hurts the most.**



3. **Please rate your pain by circling the one number that best describes your pain at its *worst* in the last 24 hours.**

0	1	2	3	4	5	6	7	8	9	10
	No Pain								Pain as bad as you can imagine	

4. **Please rate your pain by circling the one number that best describes your pain at its *least* in the last 24 hours.**

0	1	2	3	4	5	6	7	8	9	10
	No Pain								Pain as bad as you can imagine	

5. **Please rate your pain by circling the one number that best describes your pain *on the average*.**

0	1	2	3	4	5	6	7	8	9	10
	No Pain									Pain as bad as you can imagine

6. **Please rate your pain by circling the one number that tells how much pain you have *right now*.**

0	1	2	3	4	5	6	7	8	9	10
No Pain										Pain as bad as you can imagine

7. **In the past 24 hours, how much relief have pain treatments or medications provided? Please circle the one percentage that shows how much *relief* you have received.**

0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
No Relief										Complete Relief

8. **Circle the one number that describes how, during the past 24 hours, pain has interfered with your:**

A. General Activity

0	1	2	3	4	5	6	7	8	9	10
Does not Interfere										Completely Interferes

B. Mood

0	1	2	3	4	5	6	7	8	9	10
Does not Interfere										Completely Interferes

C. Walking Ability

0	1	2	3	4	5	6	7	8	9	10
Does not Interfere										Completely Interferes

D. Normal Work (includes both work outside the home and housework)

0	1	2	3	4	5	6	7	8	9	10
Does not Interfere										Completely Interferes

E. Relations with other people

0	1	2	3	4	5	6	7	8	9	10
Does not Interfere										Completely Interferes

F. Sleep

0	1	2	3	4	5	6	7	8	9	10
Does not Interfere										Completely Interferes

G. Enjoyment of Life

0	1	2	3	4	5	6	7	8	9	10
Does not Interfere									Completely Interferes	

Further Information

Can you tell us what diagnosis or name you have been given for you pain?

_____

_____

_____

Length of time (in years) you have had your pain:

_____

Please list anything you do which makes your pain worse?

_____

_____

_____

Please list anything you do that makes your pain better?

_____

_____

_____

Please list current pain medication, or attach a copy of last prescription.

_____

_____

_____

Please tell us if you are currently awaiting further tests or investigations for you pain, either from Health Service Consultants, Private Consultants or others?

_____

_____

_____

Are you happy that your pain has been fully investigated?

Yes ☐ **No** ☐

Circle the statement that best describes your current marital status:

Single **Married** **Divorced/Separated** **Co-habiting** **Widowed**

Circle the statement that best describes your employment status:

Full-time Employment	**Part-time Employment**	**Self Employed**	**Unemployed**	**Medically Retired** **Retired**

Do you suffer from any of the following health conditions (please circle)?

Heart Problems	**Diabetes**	**Epilepsy**	**Respiratory problems**	**Digestive problems**	**Gynaecological problems**
Recent Hospital Admission	**Major Surgery**	**Stroke/TIA**	**Rheumatoid Arthritis**	**Hypertension**	**Unexplained Weight Loss/Gain**
Osteoporosis		**History of Cancer**		**Tuberculosis**	

Please tell us if you have ever received psychiatric or psychological help with your mood?

Yes ☐ **No** ☐

Please indicate by circling any of the following which are sources of stress for you at present:

Family	**Friends**	**Finances**	**Work Issues**	**Other Health Concerns**

Other concerns please specify:

_____

_____

_____

Thank you for taking the time to complete this form, we look forward to meeting you at the Pain Management Programme Information Session in the near future. If you have any further queries, please contact us on [redacted]

Appendix C: List of Topics Covered in Pain Management Programme & Copies of Psychology Talks Delivered

Within this Trust, the PMP runs on a rolling basis, with approximately 5 programmes x 2 hospital sites of approximately 15 patients, running each year. It is an 8 week (22 ¼ hr) programme, comprising of:

1. Information Session (45 mins)
2. 1:1 Screening (45 mins)
3. 8 x 2.5 hr sessions
4. Review Session (45 mins)

The details of the 8 week programme are detailed below:

Week	Topic	Professional
1	Welcome and Introduction Ice Breaker Introduction to Exercise	Psychologist Psychologist Physiotherapist
2	Management of Stress Exercise Relaxation	Psychologist Physiotherapist Psychologist
3	Values Goals and Guiding Change Exercise/Relaxation	Psychologist Occupational Therapist Physiotherapist
4	Pain Pathways Exercise Relaxation	Physiotherapist Physiotherapist Psychologist
5	Managing Mood Exercise Relaxation	Psychologist Physiotherapist Psychologist
6	Pacing (Boom – Bust) Sleep Exercise/Relaxation	Psychologist Occupational Therapist Physiotherapist/Psychologist
7	Medication Management	Pharmacist Input
8	Flare Ups Exercise Relaxation	Physiotherapist Physiotherapist Psychologist

Week 1: Introduction and Welcome

14 participants were invited to attend PMP. Unfortunately, only 10 attended, 1 cancelled as a result of ill health while 3 did not attend. One participant arrived 45 mins late and took considerable time to get seated, interrupting the group. The group was predominantly female with only one male as a result of the DNA's, and the age range was quite varied.

Initial impressions of this group were that we had a challenging collection of individuals. I was mindful of the 1 gentleman and how he might feel with a group of ladies and made a mental note to make sure that any examples I utilised included both male and female aspects to ensure he felt included in the group. One lady stated at the outset that she was open to see what PMP might offer but felt her was different from the rest of the group (I felt she was slightly resistant and from the assessment I felt she was very invested in the medical model). Another lady had requested a seat close to a power socket as she had brought her heated blanket for her back (exhibiting pain behaviours). There was another participant who had done extensive research on the management of chronic pain and from a knowledge point of view – knew pretty much everything she needed to know. However, she appeared to have intellectualised this and appeared unable to operationalise any of the strategies. I was also aware of one of the younger participants who had been diagnosed with Cauda Equina and had undergone emergency back surgery. While she had been through quite a traumatic time and continued to experience pain following surgery, she presented at assessment with a positive mindset, she had already made some adaptations to her lifestyle and was keen to continue in this vein. I felt that she may be a good ally, as she was experiencing pain, just like all the other participants, but had started to take a different direction in her mindset to manage her pain differently. I felt that her examples would be useful as the other participants may be better able to relate to her experience.

Having got all participants in the room and settled I introduced myself, the other member so the team and explained the purpose of the programme and what the plan for this introductory session was. The group was quiet, which can be the case, particularly on the first morning, so we proceeded to cover the slides below. There were a number of knowing nods from the participants but little interaction at this point. I

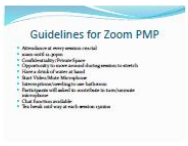
checked if anyone had any questions, to which two participants stated that it all made sense to them. We encouraged everyone to take a break and ensure that they change their position, stand up and stretch, take a short walk outside and get a cup of tea before reconvening again in 15 minutes. It was interesting to watch the level of interaction, with small groups staring to develop conversation. When we reconvened following the short break, I highlighted how it was lovely to hear the level of interaction developing in small groups and how I would like to keep that going for a few minutes longer in the ice breaker. I asked the participants to turn to the person on their right and take a few minutes to: 1. learn each others name; 2. how long they had been experiencing their pain; and 3. what they would like to achieve from attending PMP, and then feed this information back to the group. Everyone appeared nervous about this initially but engaged well. It was interrupted by the arrival of another participant who took a little time to get seated. I began the feedback by giving some information about my role in PMP, how long I had been working in the role, how I was nervous, yet excited at the start of each new group and how I hoped that everyone attending would leave at the end of 8 weeks with some idea about how they might manage their pain differently. Some participants were more forthcoming with information than others and as we got to the end of this exercise it became apparent that many were experiencing similar difficulties as a result of their pain regardless of the amount of time they had it. While this can be a time consuming exercise, which can be difficult at first for some, I feel it is really useful. It allows everyone to have a shared understanding of their pain experience, and also allows them to speak out in the group about something they know well, on the first day, which can make it easier to do again throughout the rest of the programme. It also allows us, as professionals to tune in again to the areas of most importance to each individual in relation to their pain experience so we can focus on those areas as we move forward.

We finished the program with a general introduction to exercise with some chair based exercises led by the physiotherapist, before summarising the morning, getting feedback and then thanking everyone for attending and reassuring them that we would build on todays session in Week 2.

I asked the lady who had been late to join the program if I could have a minute or two with her to run over the information she had missed earlier. I also wanted to check how

she had found the group as I had noticed her on a few occasions looking confused at some of the information being shared and discussed by the other participants in the ice breaker. She apologised for being so late, she had mixed up the start time and felt it was 30minutes later than it actually was. She also reported that she had found it difficult to follow the information presented by the other participants, which had instigated discussion at times, and stated that she found it a lot of information to process, particularly given the differing view points from the group. Knowing that this was only a taster of how these groups can be I queried if she thought this might get easier as she settled into the group and she again stated that she found it difficult to follow when there were too many viewpoints on a topic. From her assessment, there were a number of comorbid health conditions highlighted, one of which was a Stroke 2 years earlier. She was a poor historian at assessment and was vague regarding the details of her prior medical history at times, which had made me wonder abut her cognitive ability at assessment. As a result of both the assessment and my observation, and her report of her experience in the group this morning, I queried whether she felt the group approach was right for her. She told me that she really felt she needed to change how she was currently managing her pain and would like to continue with PMP and I discussed how we might still be able to cover the information from PMP in a slightly different way, which she was open to. I advised her that I would discuss this option with my line manager and ring her later in the week to advise her of the outcome. Having presented the information from the assessment and the observations from the group to my clinical supervisor and outlining a proposal that I would cover the psychological element of PMP with this lady on a one to one basis over approximately 4 sessions, through the process of supervision a mutual agreement was reached that this was the best way forward with this individual. I contacted the lady in question and outlined how we could explore the psychological element of PMP over 4 individual sessions, she was happy with this outcome and further individual appointments were arranged.

1



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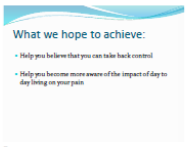

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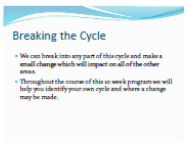

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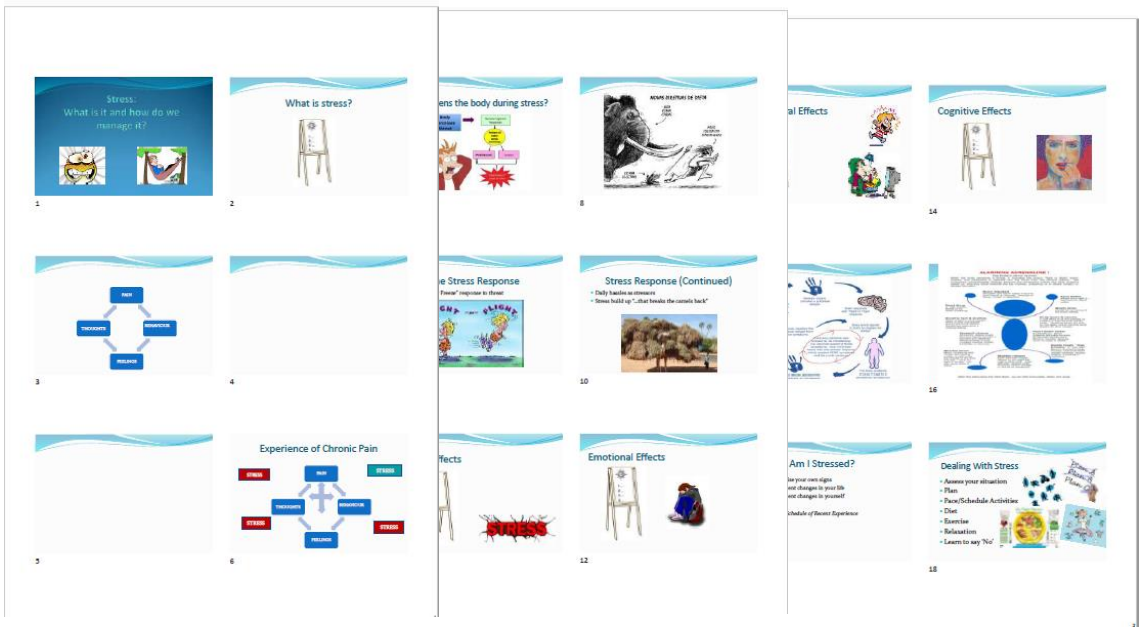
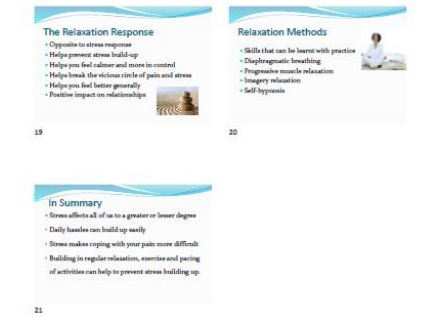
Week 2: Management of Stress

Week 2 began with nine patients and was facilitated by myself and the physiotherapist. Again, once everyone had arrived and was settled I welcomed everyone back and began by acknowledging how difficult the previous week might have been for them. I know from previous groups that many of the participants of PMP have often become socially withdrawn/isolated as a result of their pain and associated fatigue. As a result, a commitment to attendance at a group programme can be quite anxiety provoking, it can also add to fatigue/exhaustion. It requires the participant to be ready for an early morning appointment (Prog starts at 10am), which often means they need to get up earlier to allow time for medication to have an effect and to get washed, dressed and ready to leave their home, all of which can require considerable time and effort. Add to that, concentrating on a intellectually, emotionally and possibly physically challenging programme for 2.5 hours and the degree of effort required to attend the program can soon be seen. I feel that it is important to acknowledge this for all participants and it enhances engagement when they understand that those involved in their care truly appreciate the commitment they have made to the treatment. I also open up a discussion about how easy or difficult everyone found the previous weeks session, and having acknowledged the potential challenges that many overcame to attend, allows them to be honest in their feedback. This feedback was a useful segue into the Stress Management talk that forms the main presentation for this session.

While these patients, like many others are not strangers to the concept of stress or stress management, it is useful to take time to explore the bi-directional relationship between pain and stress. As I delivered/facilitated this talk I could see that one of the participants was tearful, two others appeared to be challenged, and we had two who were able to verbalise that they had recent, unexplainable flare ups of pain, that they now believed may be attributable to external stressors (although hadn't realised that at the time). Facilitating this feedback, in a manner that is sensitive to the participant is so important – it allows them to identify another aspect of their own pain management journey but doing so verbally within the group allows me to explore it fully with them and illustrate the information further for the rest of the participants from a scenario that is often

familiar to many. It is this aspect that previous participants have commented on as being different from other self-management programs that they might have attended in the past. For the participant who I had noticed as tearful during the presentation, I made a mental note to speak with her individually at the end of todays session. Following the tea break, during which there was significantly more chatter this week, chair based exercises were explored with the physiotherapist and the session was ended by introducing a short stress management tool in the form of relaxation. Relaxation was introduced by building on the diaphragmatic breathing exercises already introduced by the physiotherapist and progressing to a progressive muscle relaxation. While the majority of participants appeared to engage fully with this element of todays session, two appeared to find this aspect difficult. Once the relaxation exercise was complete, I tied this back to the stress management talk earlier and reiterated how important stress management techniques were in the management of chronic pain. I explained that over the course of the next 6 weeks we would explore other relaxation techniques but encouraged everyone to try and integrate some of the exercises and the relaxation into their routine on a daily basis, as just like medication they were part of their pain management strategy. As everyone got up to leave I spent just a few minutes individually with them as they were leaving to check how they had found todays session which also allowed me to touch base with the tearful participant from earlier in the session without other participants seeing this as unusual. She was able to let me know that she had been able to fully identify with the information presented, however felt she had little power to manage the external stressor which is where her distress had come from. She told me that she was managing the situation as best possible and was keen to practise the relaxation over the coming week as she had found it beneficial in session.


Stress:
What is it and how do we manage it?
What is stress?
Stress Response
Stress Response (Continued)
Cognitive Effects
Experience of Chronic Pain
Emotional Effects
Dealing With Stress
Assess your situation
Plan
Pace/Schedule Activities
Diet
Exercise
Relaxation
Learn to say 'No'

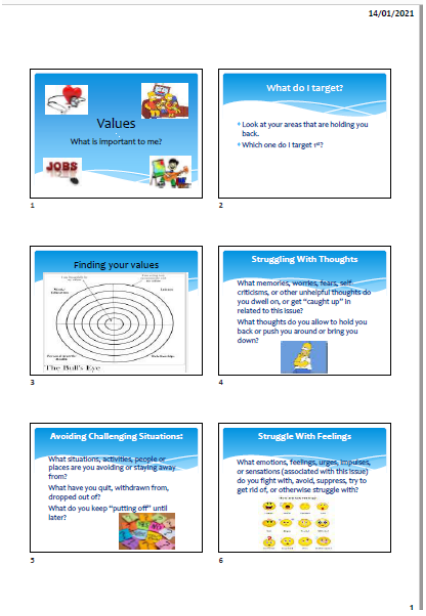

The Relaxation Response
Opposite to stress response
Helps prevent stress build-up
Helps you feel calmer and more in control
Helps break the vicious circle of pain and stress
Helps you feel better generally
Positive impact on relationships
Relaxation Methods
Skills that can be learnt with practice
Diaphragmatic breathing
Progressive muscle relaxation
Imagery relaxation
Self-hypnosis

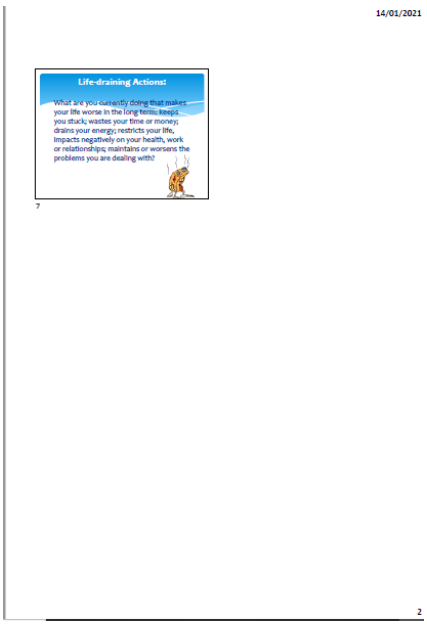
In Summary
Stress affects all of us to a greater or lesser degree
Daily hassles can build up easily
Stress makes coping with your pain more difficult
Building in regular relaxation, exercise and pacing of activities can help to prevent stress building up.

Week 3: Values

Week 3, again we had 9 participants. This week it was me and the Occupational Therapist, as the physiotherapist was unavailable. I started the session by checking in with everyone, how they had found the information presented last week, any queries regarding it and if they had been able to get some exercise and relaxation practise over the past week. One participant began by challenging the fact that stress might negatively impact on pain, they stated that the relationship whereby pain caused stress could be understood easily, they felt that suggesting that stress may cause a flare-up of pain was too simplistic. As I started to address this two of the other participants started to speak also. They debated who would speak first, however both had the same idea. Both had experiences in the past week where their pain had increased, both were able to relate this to a period of intense stress as a result of having attended the session last week and I feel that their examples were more beneficial than any explanation I could have given. We moved on to a grounding exercise, to illustrate another stress management tool, prior to the presentation. As I explored the importance of values and how they bring meaning to your life, I asked participants to take 5 minutes to think of areas of their life that they felt restricted in as a result of their pain. I was mindful of my assessments with this group of participants and knew that there were key areas here that most could identify if they felt safe enough. I was also hopeful that 2 participants, who were perhaps more willing to be open in the group, would share their thoughts so we could use those to explore the topic further. One participant started to share their thoughts on this and sparked discussion within the group which allowed me to tease this concept out further using issues that were relevant to the participants. We used these examples as we moved through the presentation to good effect and asked all participants to take some time at home, between sessions to write down their values and explore if they were currently working towards those at present. Knowing that this can be a difficult task for some, I let them know that I would be available if they would like to discuss these further next week between presentations. We finished this presentation by showing a short online video clip called 'Knowing your Why'. At this point we took a short break and then with the Occupational Therapist I proceeded to highlight the relationship between values and goals before she moved into the next

presentation properly. While the occupational therapist led this presentation, I was able to add to the discussion as it emerged with key points from the earlier presentation as well as helping participants identify the goals they had already set and completed in relation to the group itself. Once the presentation had ended and we had assisted everyone in identifying key short term goals, we asked everyone to take a 5 minute break before returning to do a short relaxation to finish the morning. We built on the previous weeks relaxation and started with taking some deep breaths, followed by the progressive muscle relaxation from the previous week and added in a short, generic, visualisation exercise. This appeared to work well, although I was aware that there were a few who took longer to relax than others. We discussed the additional visualisation and how this could be adapted and personalised to something that held more meaning for them. They were encouraged to practise this over the coming week and we would revisit it again at the following session.





Week 4: Relaxation

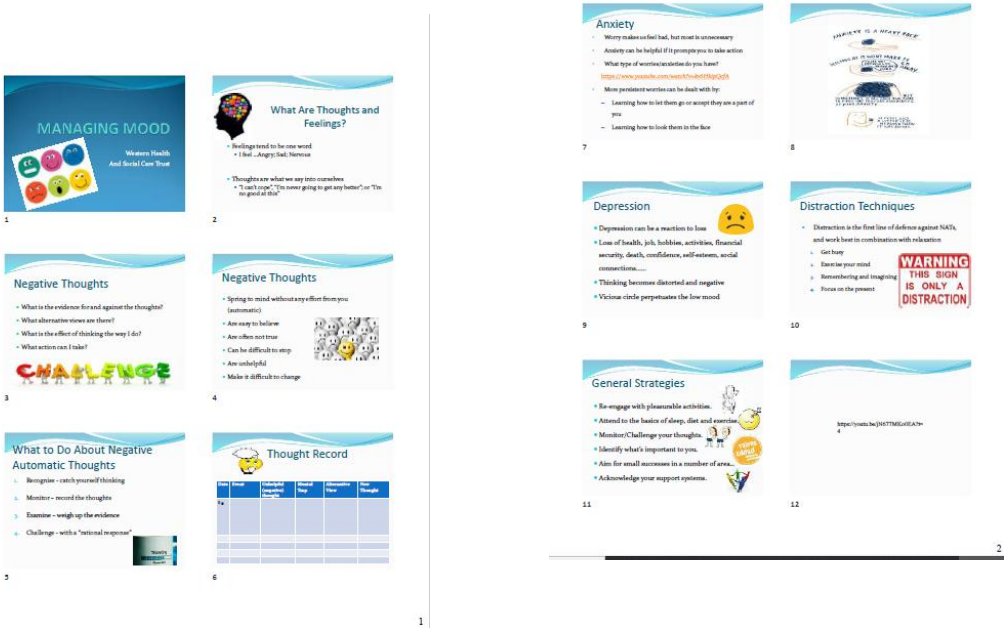
While the presentation of information fell solely to the physiotherapist this week, I was also present for the group. I had planned to deliver another relaxation session at the end of the session, however I also felt that having discussed values last week, I may need to revisit this informally with at least one or two of the group this week. Its also useful to be present during the talks delivered by the other professionals as each talk has been designed to complement and expand each other. This means that if an individual hasn't fully picked up on something from my delivery, they may pick up on it during a later (seemingly unrelated talk), and it is important to be able to tease that out for them at that time. There are also elements of this talk regarding pain pathways that can provoke strong reactions from some and being able to explore this with participants at that time rather than at a later session is really useful. So while my presence was not essential this week in terms of information delivery, in order for the majority of participants to get as much as possible from the PMP, psychology being involved at each session is essential.

Week 5: Managing Mood

Full participation again this week with myself and the physio in attendance. Lots of interaction and discussion within the group before we got started – easy to see that most participants are becoming more familiar and comfortable with each other, and with us. I have noticed over the years that while each group is different, that it generally takes at least 3 weeks for the participants to become anyway comfortable with each other, us and the information being presented. Its almost like a 'light bulb moment' for some. As a result of everyone being that bit more comfortable with each other this talk felt less threatening to deliver to the group. I say that, as depending on the group, the talks on mood and the more emotional aspects of pain management can be difficult for some to engage with. I believe that this group had two participants that weren't fully ready to hear this talk, however I felt the rest of the group were more than ready to hear it and were able to hold the other two participants in a safe environment with it too. There were a few tears for some, but I explored this and found that they weren't tears of distress, more of recognition as well as relief that as professionals we understood this was part of the pain experience. We took a break half way through this talk as the level of interaction dictated it, and did our exercise component just after the break before we came back to the talk. Participants are now at a stage where they are more trusting of exercise and the fact that it is not designed to add to their pain and really appeared to enjoy this session. When we returned to the talk, one of the participants that I felt this talk would be difficult for became visibly and verbally upset. She stated that she felt we were going back to what she had heard from other health professionals in the past 'her pain was all in her head'. While this was not unexpected, I hadn't actually expected it to be phrased in such a direct manner at this time. However, it allowed me to address this head on within the group, and while the rest of the participants remained silent for the most part, one or two contributed key points that really helped support what I was saying. I was mindful to thank the participant that raised the issue, as I felt it had taken quite a lot of courage for her to do so, and I am sure that there were maybe others in the group who had either heard of felt this way in the past so it was useful to be able to address this openly as a group.

I finished the group with a longer relaxation script, which again we broke down into its component part so that participants could see how they might use smaller elements at times when they had less time, or use it all but more tailored to their own scenarios.

As the group finished I reminded everyone that we had a weeks break (due to a national holiday) and that we would reconvene in two weeks time to review and refine the goals we had explored previously.

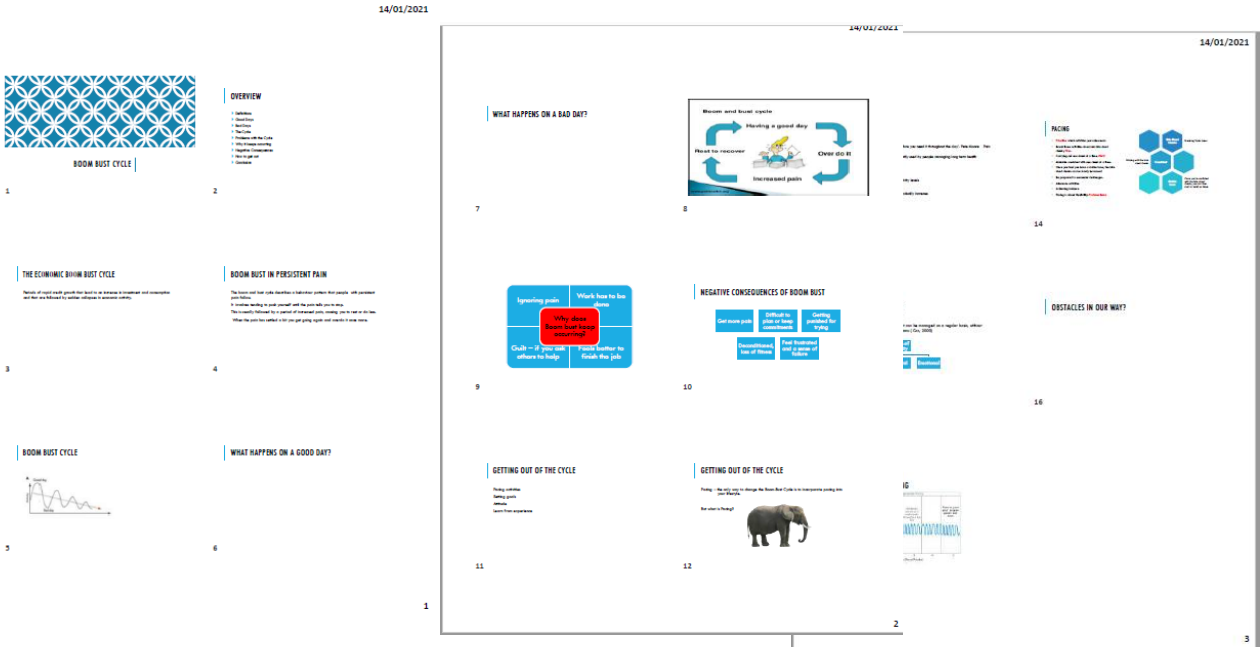


Week 6: Boom Bust Cycle

Week 6 was very different to how we expected. Unfortunately as a result of COVID 19, all face to face outpatient clinics in the Trust were suspended – Thus we were unable to hold the PMP this week and instead used this time to regroup and informed the patients that we would inform them about the way forward as soon as possible. I consulted with my clinical supervisor as well as the physiotherapist and occupational therapist about how we would proceed. The occupational therapist told us that she had already spoken with her line manager and would be unavailable for any further sessions as she had been instructed to 'shield'. The physiotherapist had also been instructed that she may be redeployed within the community so was unsure what she could commit to. As a result of this I proposed that we move forward with the last 3 weeks via tele-health, sending the powerpoint talks to the patients in advance and then following up with each one individually to 'flesh out' the talks and explore the topic further. While this would increase the workload at present, I felt it was the best way to continue the momentum already established in the group and complete the program for this group. The physiotherapist agreed with this approach, however, unfortunately we were unable to involve the pharmacist as she had already been redeployed to the COVID ward. Therefore the last 3 weeks of the group were delivered via telehealth with the Pacing, Sleep, Medication and Flare-ups talks sent out to the patients in advance of two calls from myself and two calls from the physiotherapist. This certainly changed the nature of the programme but allowed us to complete the programme for the majority of patients.

I actually think that for a few of the patients the change in delivery from group to individual via telehealth was beneficial and allowed them to explore not only pacing but also go back to the values and explore it in more detail as they were more comfortable discussing this in an individual setting. Obviously for the participant who preferred to wait for the next face to face programme, they found the group aspect beneficial. It was interesting to find out that for many of the participants sleep had been a big issue at the outset of the programme, however had started to change for many as the programme progressed. They attributed this to the fact that they were practicing both the relaxation and exercises covered in PMP and many had also started to incorporate small walks into

their weekly routine. They talked about how PMP had been difficult initially on a physical and emotional level but as the weeks had progressed they felt the achievement of being able to commit to something on a regular basis (attendance at the programme) and realised that they could maybe do this in other ways, and felt that this had helped them be more physically tired going to bed. I know from talking with the physiotherapist that she was able to tease this out further so that some of the participants realised that their physical activities, on a controlled and graded basis was maybe decreasing their pain also.



Week 8: End of Programme

Following the physiotherapist phone call to cover the information regarding flare ups, I rang all participants to ensure they had a good understanding of all the information presented throughout the programme and to reinforce the pmp approach. While most appeared to have understood and were already applying many of the principles, I was most surprised with the participant who had been heavily invested in the medical model at the outset. I had noticed a shift in their degree of openness to the PMP model at our last face to face session and had been concerned that these gains would be lost given the break in the programme. It appears that the opposite was true. The shift in her thinking, combined with the physical lockdown (working from home, homeschooling, no after schools activities, a slightly slower pace) had allowed her to see that there may be some merit in the PMP approach, as many of her symptoms had reduced in just those couple of weeks. For the most part the other participants had made some gains and were starting to see how the PMP approach could make a difference to their pain management but needed time and perseverance to see how they could benefit most.

This programme was definitely not the normal run of things given the circumstances, however, given the constraints we had I believe we achieved a lot and feel that that was due to the therapeutic alliance we had achieved with these participants prior to lockdown.

Grounding Exercise

This technique will take you through your five senses to help remind you of the present. This is a calming technique that can help you get through tough or stressful situations.

Take a deep belly (which you would have practiced as part of the PR) breath to begin.

5 – LOOK/SEE: Look around for 5 things that you can see, and say them in your mind. For example, you could say, I see the computer, I see the cup, I see a picture frame.

4 – FEEL/TOUCH: Pay attention to your body and think of 4 things that you can feel, and say them in your mind. For example, you could say, I feel my feet warm in my socks, I feel the hair on the back of my neck, or I feel the pillow I am sitting on.

3 – LISTEN/HEAR: Listen for 3 sounds. It could be the sound of traffic outside, the sound of typing or the sound of your tummy rumbling.

2 - SMELL: Notice two things you can smell. If you can't smell anything at the moment or you can't move, then name your 2 favorite smells.

1 - TASTE: Say one thing you can taste. It may be the toothpaste from brushing your teeth, or the taste of your lunch. If you can't taste anything, then say your favorite thing to taste.

Take another deep belly breath to end.

Appendix D: Behaviour Change Techniques Employed

Taken from (Dixon, 2010)

Topic		Professional	HBCC competency used in this PMP				
			Foundation Comp	Behaviour Change Comp	Behaviour Change Technique (route to behaviour change)		
					M	A	P
1	Welcome and Intro Ice Breaker Intro to Exercise	Psychologist Psychologist Physiotherapist	F1, F2, F3, F4, F5, F6, F7, F9, F11	BC1	M20, M17, M12, M11	A12	
2	Manag of Stress Exercise Relaxation	Psychologist Physiotherapist Psychologist	F10, F8, F6, F11	BC1, BC3	M10, M21, M14, M18	A12, A9, A15, A18, A20, A13	P9, P11, P13, P47, P38
3	Values Goals & Guiding Change Exercise/Relaxation	Psychologist Occ Therapist Physiotherapist	F3, F5, F10, F6, F7, F12, F8, F11	BC1, BC3, BC4, BC10, BC7	M20, M10, M1, M13, M15, M2, M21	A3, A1, A8, A4, A2, A5, A15, A20, A22, A11, A17, A30	P15, P3, P8, P9
4	Pain Pathways Exercise Relaxation	Physiotherapist Physiotherapist Psychologist	F6, F11	BC1		A1, A10, A18, A13	P2, P11, P13, P47
5	Managing Mood Exercise Relaxation	Psychologist Physiotherapist Psychologist	F10, F6, F8, F11	BC1, BC3, BC4, BC10, BC7	M1, M13, M15, M18, M14	A9, A10, A4, A15, A18, A20, A13, A16, A30	P2, P9, P11, P12, P13, P17,P47, P38
6	Pacing (Boom/Bust) Sleep Exercise/Relaxation	Psychologist Psychologist Physio/Psychologist	F10, F6, F8, F11	BC1, BC3, BC4, BC10, BC7	M20, M10, M1, M13, M15, M18	A10, A4, A5, A20, A22, A11, A17, A30	P15, P2, P8, P9, P12
7	Medication Management	Pharmacist Input	F6, F11	BC1		A10	
8	Flare Ups Exercise Relaxation	Physiotherapist Physiotherapist Psychologist	F6, F11, F9	BC1, BC9, BC12		A10, A18, A16, A13	P11, P13, P17, P47

Chapter 3: Teaching and Training

Teaching & Training Case Study

Introduction

For this reflective account I selected the final teaching series delivered at a local health care trust, to a group of ten practitioner psychologists working in the health psychology department. This teaching series was entitled 'Psychoneuroimmunology in Health Psychology', and demonstrates my professional development over the previous two years of experiences to achieve my teaching competence. This teaching series was chosen as, although I am not an expert in this area, I was able to offer insight, interest and enthusiasm to examine the topic with a range of practitioner psychologists from a range of professional backgrounds (i.e., Clinical Psychology and Counselling Psychology), now working in the area of health psychology. Given that I am still in training and many of the participants were fully qualified practitioner psychologists with professional experience, I considered myself as facilitating an exploration of this topic, willing to incorporate examples from their experience which may be outside of my direct expertise.

Assessment of Training Needs

Having identified my client group, it was useful to spend some time initially assessing their training needs and developing a learner profile. Developing a learner profile is a useful task to complete before progressing along the path of determining learning objectives. This allowed the sessions to be designed to fit the target audience and address any learning gaps identified. To identify learner goals, I adopted a pragmatic approach and considered three specific factors: 1. What they might want to know; 2. How they might use what they learn; 3. What goals they have in attending the teaching series.

A good understanding of the audience (I have worked with most of them for some years), allowed me to start the teaching process from where they were at, what they already know and what examples might be useful to illustrate the information more clearly.

I reflected that they all had a shared experience in that they had studied psychology at undergraduate level, therefore starting from this level helped me reduce obstacles to clear communication.

Kaufman (2003) suggested that an essential element of any teaching is to take into account the prior experience and knowledge of any learner. To identify what needs and outcomes might be expected within the context of this topic I reviewed the current training requirements in the Liverpool John Moores Module Guide.

Experience of delivering group-based psycho-educational programs within the course of my work has led to an understanding that didactic techniques rarely engage an audience. With any teaching I feel it is important to understand your audience and what style of learning they may be most familiar with. Having been part of this team for some years, I was aware that the more Socratic style of teaching would work best and the content was designed around this knowledge. Unfortunately, the mode of delivery in this case was synchronous online training as a result of the COVID 19 restrictions, and while the Socratic style of teaching would have worked best in a face-to-face delivery, it does not lend itself well to online teaching. As a result, a more didactic style of teaching was adopted.

Training Programme Structure and Content

A clear outline of a programme structure offered clarity to both learner and teacher/facilitator. Having identified from online diaries which day most staff would be available, I consulted with them regarding the when and where of delivery. As a result of COVID-19 restrictions regarding cross contamination when travelling between hospital sites, home working, and difficulty accessing some of the bigger training rooms as they had been repurposed for administration staff, online delivery appeared to be the most suitable way forward. Everyone was constrained in terms of the time available for training given the extra pressures during the pandemic, therefore we agreed that lunchtime sessions would be most suitable in terms of efficient use of time. It was agreed that 5 weekly sessions, occurring on a Thursday at 1.30pm for 30mins each time would work best.

Learning is an active, dynamic process (Cross, 1999) therefore I felt that to help participants fully engage in the teaching series introducing concrete examples, relevant to their own experience, would be most useful. Where suitable, I used current examples from within my own caseload and analogies to try and illustrate the application of the information being presented. In line with Race's (2015) pointers for a memorable lecture, I began each session by detailing what we would cover and its importance, and then ending the session with a summary of both of these, putting it into context of the work we are all involved in. The slides from each session were made available directly after the session on a shared drive that is used within the department for sharing of information. This allowed participants to revisit anything that they felt they did not get full information on or needed clarity around prior to the next session. As a result they were then able to fully utilize the next session to ask any further questions from the previous session that had not been addressed. I was mindful of the fact that after 10 minutes of listening, most participants' attention will drop (Bligh, 1985). While the sessions were short, being only 30 minutes long, I still felt it was important to incorporate short breaks from listening throughout the session. This was facilitated by including the use of short video clips, breaks to discuss aspects of the session so far and short summaries to allow participants to query any aspects of the information they required further clarification on. I also made a conscious effort to minimize the amount of text used in the PowerPoint presentation, and where possible employed the use of SmartArt graphics, short videos and relevant images as points of discussion rather than overwhelming the participants with large volumes of text which may reduce the ability to understand and assimilate the information (Mayer and Moreno, 2003).

In terms of content, again consultation with the learners identified that despite having studied psycho-neuroimmunology at undergraduate level, it was felt that a more in-depth look at how it could be applied in health psychology, specifically in particular conditions, would be useful. With this in mind, as well as the fact that some time had passed from the initial undergraduate training, I felt that beginning the sessions with a brief introduction was appropriate. This was followed by sessions in Acute Stress: Stress

Pathways, Stress Hormones and Immunity; Chronic Stress: Maladaptive, Cortisol and metabolism, Diabetes, Cancer, Long Term Conditions, Health Behaviours, Role of Health Psychology; COM-B and its role in addressing health behaviours in diabetes; Summary & Questions. See Programme Structure and Content in Appendix 1.

Learning Outcomes and Assessment Methods

Learning Outcomes

Reflecting on my expectations for the session was important initially as the assumption could be made that both learner and teacher expectations were the same and from experience this is rarely the case. Also, it was important to consider exactly what it was I wanted to achieve, i.e., to deliver a series of 5 introductory sessions on psychoneuroimmunology with a strong focus on its application in health psychology, as well as to inspire learners to further explore the topic.

I was acutely aware of the time constraints of the participants and consulted them as a group to establish their expectations and availability prior to beginning the sessions. The learning outcomes were developed in collaboration with the participants at the beginning of the first session and were as follows:

- All participants/students should be able to apply at least one aspect of psychoneuroimmunology to their current caseload.

- All participants should have an awareness of the role of psychoneuroimmunology across condition specific areas such as: Cardiology, Pain Management, Diabetes, Respiratory, Renal and Oncology specialties.

- All participants will provide evidence of progress in closing the practice gap by discussing how they have been able to apply the knowledge in a recent patient case study.

Learning Theories

Domains of Learning

When we explore the different domains of learning Bloom's Taxonomy (1956) comes to the fore; it identifies three domains as highlighted below:

1. Cognitive (knowledge and intellectual skills)
2. Psychomotor (physical skills)
3. Affective (feelings and attitudes)

These domains can be broken down further to form hierarchies of objectives of increasing complexity and can aid in the evaluation of teaching.

With this training the delivery and exploration of the information with participants met the first, cognitive domain. Following that, as sessions progressed and the knowledge was applied to caseloads and allowed for reflection, identification of skills to implement the knowledge was facilitated and analysed. This then allowed for a synthesis and evaluation of this knowledge and whether or not it could be implemented in practice.

Another influential figure in describing how learning takes place is Kolb (1984), who described a learning cycle that required four kinds of learning contexts:

- Concrete experience;
- Reflective observation
- Abstract conceptualization
- Active experimentation

In planning any teaching it is important to take into consideration that opportunities for these learning contexts must be included.

Wolf (1984) also suggested that in developing different learning styles, a preference for some modes of learning tends to emerge, that fit within that learning cycle.

With this training, participants were encouraged to take time following each session to consider how the teaching material applied to their current caseloads, i.e. have a concrete experience of the material in relation to their workload. This was then reflected and built on throughout the remainder of the sessions. As the reflections developed participants were able to make generalisations and put a plan in place of how they could integrate this learning into future cases. This therefore facilitated that active experimentation which is essential to fully integrating any learning.

Others such as Honey (1992) and Biggs (1987) have also developed ideas of learning styles which have been widely used. However, in developing this teaching I was mindful of the work of Becher (2001) who described medicine and other health professions as 'hard applied' subjects. They highlighted that there are often competing tensions between underpinning science, research and clinical practice and that these must be accommodated within any curricula in this field.

Schön (1987) has also looked at the development of the reflective practitioner. Providing opportunities for learners in more professional settings to develop skills through practice, and reflective practice is thought to be essential. This training facilitated reflective practice to some degree, however, I would have preferred to facilitate stand-alone reflective practice sessions, particularly towards the latter part of the teaching series.

Critical Evaluation

I am very aware of a shift in my confidence levels between the start and end of this series of training sessions. I have been involved in delivering psycho-education programs to both patients and health professionals on numerous occasions over the past ten years and, while I was nervous and not at all confident to begin with, over time I felt this had improved. Therefore, initially I did not anticipate any difficulty in delivering

this training to my co-workers. In hindsight, that was quite naive of me. The fact that I had worked with these individuals over many years meant that I had good information starting out, in terms of their knowledge base and what might be useful for them in terms of the content of the training. However, I had neglected to acknowledge just how nerve wracking it might me to deliver a piece of training to them. In theory, the fact that I know them well meant that I was concerned about their judgement, if I happened to do a particularly poor job. Rationally, I know that as my colleagues, they would not have judged me harshly, they would have merely guided me in the right direction to address any issues but initially my anxiety had increased prior to the training. What I found was that following the first session (introductory) this subsided, and my confidence levels increased. I think that having assessed the general knowledge base I possibly overestimated the potential for accrued experiential learning. While I focus on the psycho-neuroimmunology aspect of each patient that I assess, I am now aware that more senior staff, who are working with the more complex patients may be working at a completely different level and not always explore the psycho-neuroimmunology aspect of the case.

In terms of the actual delivery of the training, I had prepared quite a large degree of content to deliver over the course of the five, 30-minute sessions. While the 30-minute sessions suited the department given the pressures of the pandemic, it was a particularly limited amount of time to deliver training and facilitate a full evaluation of the teaching series. While I was able to deliver the content as detailed in the appendices, I am aware that it did not allow for as full a reflective practice session as I would have liked, which I had hoped would form the basis of my evaluation. I was able to facilitate limited reflective practice throughout the sessions, however I feel my evaluation was weak as a result of this. One of my colleagues in particular expressed an interest in finding out more about how psychoneuroimmunology had an impact on diabetes; ideally, if I had been able to have longer sessions I would have been able to devote half of the next session to this. Given the time constraints I addressed the direct queries at the start of next session and supplemented this with directions to additional reading that I had added to a department shared folder, so that everyone could access if they wished. Copies of all the information presented (as detailed in Appendix 1) were also added to

the shared folder following each teaching session to allow participants the option to keep these for further reference or go over points that they would like to query further at the next session. In hindsight, if I was delivering the same teaching series again to similar participants, I think I would perhaps lessen the content for each session and deliver it over a longer period of time, possibly 8-10 sessions, which would allow for much more of the reflection and analysis that would in turn fully facilitate the potential for integration into practice, which Bloom (1956), Wolf (1984) and Schön (1987) felt was essential.

A practical aspect of the teaching that I had not anticipated being an issue was the online delivery. Looking back, this is something that I should have given greater attention in my planning. While the online delivery via Zoom was generally fine, we did have one day where we had to cancel and reschedule as a result of having unresolvable issues with the volume, meaning that the participants were unable to hear me. This certainly initiated my stress response, however, using the chat function of Zoom I was able to communicate my difficulties and re-arrange the session to suit the participants. This is one major advantage of the online delivery method, for this group of students. Healthcare professionals are often geographically distant from each other, often spread across numerous hospital and community sites. This year, they are also having to embrace 'working from home' where possible. Online delivery of teaching in this instance improved accessibility, addressed time pressures and employed a large degree of flexibility. Had this same teaching been delivered in a face-to-face session and needed to be rescheduled as a result of technical issues, this would have been at great expense to the NHS, in terms of travel costs, and clinic downtime. Rescheduling an online teaching session resulted in approximately ten minutes of clinic downtime with no associated travel costs. Looking back another practical element which I would change about the teaching would be to send a reminder via email to everyone on the morning of the training with login details etc. There were two sessions where a few of the students were late joining as a result of either misplacing the login details or forgetting about the session. A reminder email would have addressed this easily and was something that I employed for the last three sessions

My teaching style tended to be a blend of teaching and facilitation. I feel that this was the result of having worked with the participants for quite some time and having already established equal relationships. It may also have been due to the fact that the participants were all adult learners who were motivated to learn and were eager to combine a lecture style delivery with case study discussion. Despite an awareness of a range of models of learning styles, such as Kolb (1984), Honey (1992), and Fleming (1992) to mention a few, I am also aware that these are also a matter of debate in how important or not they may be. With this in mind, rather than rely on any particular learning model, I engaged with the learners prior to developing the teaching series to identify if there was a particular style that appeared to work best for them. I identified that for the majority, while they were eager to learn, they had little free time – hence the delivery of five 30-minute sessions over what is traditionally a lunch period. I was also able to identify that some preferred to be more independent learners, while others preferred the interactive, 'involving others' approach. What was clear for all was that the increased reliance on online methods of interaction generally had led them all to the conclusion that the teaching needed to be somewhat interactive to aid engagement. So, while the planning delivery was teacher-centred, it also involved co-operative learning. I feel that this was appropriate given that this teaching was delivered to a group of professionals who were all peers. I also feel that the combination of the two methods of delivery allowed me, as the teacher, to gauge both uptake of information as well as the potential to apply the information in practice moving forward. Taking time to observe the engagement, if only from an observational perspective allowed me to identify that participants were behaviourally, psychologically and cognitively engaged (Buckley, 2018). In terms of behavioural engagement, attendance at all sessions was as had been indicated by the participants, given the nature of a hospital environment, not everyone was available to attend on all occasions, however those who indicated that they would attend did. Participation throughout the teaching series was evident in the level of interaction displayed, the questions asked, notes taken, and case examples discussed. In terms of emotional engagement, there were no obvious displays of agitation or sadness and in the evaluation forms received there was mention of a quote used being 'poignant', highlighting the emotional component. Cognitive engagement was obvious in the additional information sought, and the discussions around the application of it to particular cases, which also allowed me to judge the uptake of the

information presented and how it might be applied by the participants in practice. Engagement is something to be mindful of in planning and delivering any teaching, given the relationship that exists between participant engagement and teaching effectiveness, however, it is a challenging concept to measure (Stephenson et al., 2020).

In planning this series of teaching, I was very conscious of the fact that I had five, 30-minute sessions to deliver quite a large volume of information. As a result of this I felt that each session needed to be succinct, with key information points that the learners could take away from each session. To ensure this I employed Aristotle's triptych: 1) Tell them what you're going to tell them; 2) Tell them; 3) Tell them what you've told them. While this seemed to be repetitious for me as the teacher, it appeared to work well for the participants, as each session ended with a recap of the main points, which generally provoked discussion of the material covered and how this applied to current caseloads. This allowed me to evaluate whether the learning outcomes were achieved, as I was able to assess: 1) the level of application to current caseload from the discussions regarding particular cases; 2) using case examples from particular conditions, identify if participants could identify the role of psychoneuroimmunology in those cases, by encouraging problem solving discussions; and 3) discussing the potential to apply this knowledge in practice, allowing open discussion as to how this might be pursued. While this may not be considered a formal evaluation, I feel that it was the most respectful and effective method for assessing the learning in this particular group of students. Not only was it effective in terms of time management, it was also a way of aiding engagement as we moved through the five sessions.

Student Evaluation Forms

Examples of student evaluation forms can be found in Appendix 2. Unfortunately, while all seven participants were sent an evaluation form for each week, only two were returned. This is possibly a result of the time pressures on health professionals generally, allowing time for attendance at training but potentially little time for reflection on learning thereafter. Following this experience, going forward with online training I intend to incorporate a short online evaluation which is built into the teaching time to capture this potentially useful feedback. The evaluations that I did receive were

positive and highlighted the learning from the session for the participant as well as commenting on the layout and use of video as being engaging and informative.

Peer review, included in Appendix 3, suggested that the training was a useful addition to existing CPD and served to refresh staff awareness to the impact of stress on the individuals that we treat. Delivery style was highlighted as being relaxed yet methodical, and while that may not have been exactly how I felt, I am glad that it appeared that way to those attending the teaching series.

Suggestions for improvement

Following completion of the training and taking some time to reflect and evaluate it, there are a few areas that I feel could be improved upon.

1) Mode of Delivery: While the mode of delivery in this instance was dictated by the current pandemic and was found to be both time and cost effective, I would like to employ more of a hybrid or blended model of delivery moving forward. The online mode of delivery facilitated staff attendance from a range of physical bases without additional travel time. It also remained focused throughout possibly as a result of tight time frames. However, I feel that in the future I would build in the option to follow the teaching with a face-to-face reflective practice session, which would potentially consolidate learning and aid evaluation of the teaching. This would allow more time for each individual to take a particular case and discuss how they applied the psychoneuroimmunology knowledge in practice, and therefore identify potential learning gaps for some.

2) Homework/Between Session Tasks: In hindsight, I feel that the addition of a task between sessions might have been extremely valuable. Tasks such as applying that week's learning to one of their cases and reflecting on their experience might have been a useful addition, had we had more time. Other tasks might have involved asking them to identify a recent article in this area and summarizing this for the next session. As I move forward I would be encouraged to build in additional time to explore these aspects further.

3) Evaluation: As mentioned in Point 1 above, a blended mode of delivery would allow for more robust evaluation of the learning. However, working from a purely online

mode of delivery I would change the evaluation method. In this instance, while delivery was online, participants were asked to complete an evaluation form and return via post. This clearly did not work as there were only two evaluations returned. I believe that incorporating an online evaluation into the summary at the end of each teaching session, would be more beneficial and ensure that everyone had the opportunity to give their feedback prior to leaving the session and potentially forgetting to complete the evaluation. The other option which may have been useful here would have been to include a short quiz, either at the end of a session or perhaps more ideally at the beginning of the next session. This would aid not only evaluation of the training but also planning of any further teaching.

In considering the piece of teaching delivered, as well as the potential improvements highlighted above, I believe that while I conducted a worthwhile teaching series on this occasion, going forward, I would potentially deliver this same teaching, however it may be fundamentally different. Obviously having highlighted suggestions for improvement, I would incorporate those into any future training. However, I am also aware that during the course of delivering this training (5 weeks), I have grown in confidence, and I can only assume that as I progress in my career this confidence will increase further. While confidence levels may not be something we can quantify, it is certainly a element of professional practice, in any capacity that cannot be ignored. Having commenced my career a number of years ago as an assistant psychologist, I was tasked with 'filling the breach' in delivering elements of a psycho-education programme that had been established. I remember the initial fear and how that took a considerable time to subside. It also required me becoming more familiar with the content and adapting it to my own style of delivery, as well as getting to know the particular client group I was working with. On top of all that, the old adage of 'Practice makes Perfect' resulted in my confidence levels rising as my career progressed. I imagine that as I continue to complete the competencies required for my Professional Doctorate in Health Psychology, my self-belief and confidence will grow further. As a result of that while this training may be delivered again in the future, I expect that both experience and confidence will play a key part in improving the quality and delivery of it.

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Appendix 1: Program Structure and Content

Week 1

Psychoneuroimmunology in Health Psychology

Tracy McCrossan MBPsS
Trainee Health Psychologist

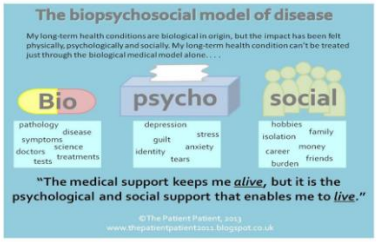
Psychoneuroimmunology (PNI) in Health Psychology

- Week 1: Introduction to PNI
- Week 2: Acute Stress
- Week 3: Chronic Stress
- Week 4: COM-B
- Week 5: Summary
- Questions?

Health Psychology

- *The biopsychosocial model describes interactions between psychosocial and biological factors in the aetiology and progression of disease. How an individual interprets and responds to the environment determines responses to stress, influences health behaviours, contributes to the neuroendocrine and immune response, and may ultimately affect health outcomes.*
- ***Health psychology interventions are designed to modulate the stress response and improve health behaviours by teaching individuals more adaptive methods of interpreting life challenges and more effective coping responses.***"
- Lutgendorf, S., & Costanzo, E. (2003). *Psychoneuroimmunology and health psychology: An integrative model.* Brain, Behavior, and Immunity (17) 225-232

The Bio-psycho-social model

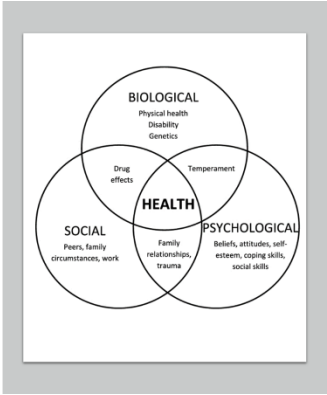


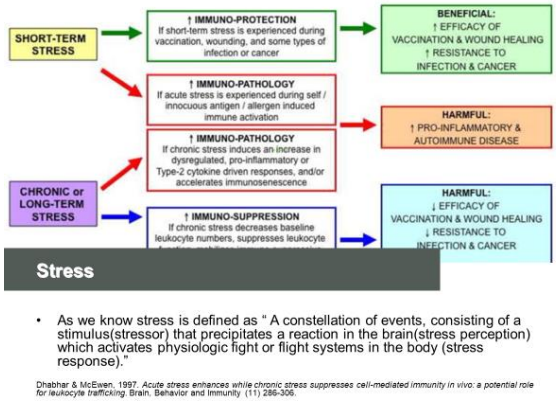
Dr. Chris Bjorndal – Psychoneuroimmunology

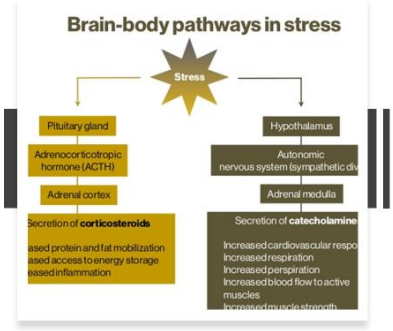
https://www.youtube.com/watch?v=sabuBhSIffI

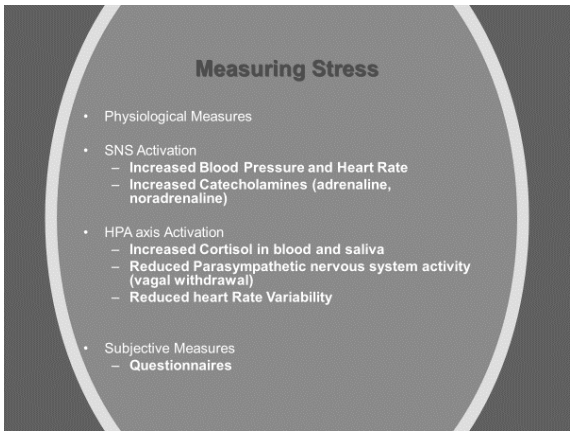
Psychoneuroimmunology

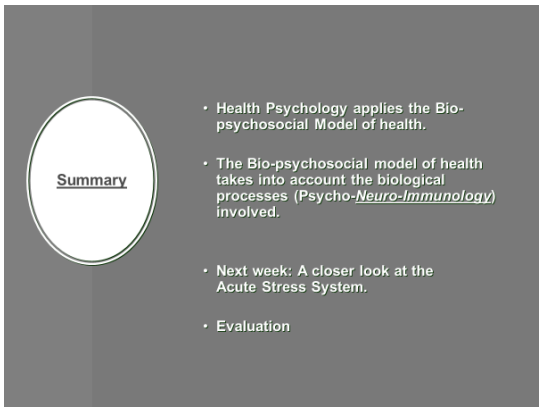
- Psychoneuroimmunology : the study of the bi-directional communication between the brain and the immune system



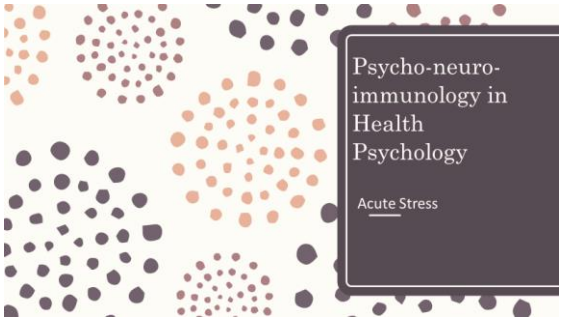

SHORT-TERM STRESS
↑ IMMUNO-PROTECTION
If short-term stress is experienced during vaccination, wounding, and some types of infection or cancer
BENEFICIAL:
↑ EFFICACY OF VACCINATION & WOUND HEALING
↑ RESISTANCE TO INFECTION & CANCER
↑ IMMUNO-PATHOLOGY
If acute stress is experienced during self / innocuous antigen / allergen induced immune activation
HARMFUL:
↑ PRO-INFLAMMATORY & AUTOIMMUNE DISEASE
CHRONIC or LONG-TERM STRESS
↑ IMMUNO-PATHOLOGY
If chronic stress induces an increase in dysregulated, pro-inflammatory or Type-2 cytokine driven responses, and/or accelerates immunosenescence
↑ IMMUNO-SUPPRESSION
If chronic stress decreases baseline leukocyte numbers, suppresses leukocyte
HARMFUL:
↓ EFFICACY OF VACCINATION & WOUND HEALING
↓ RESISTANCE TO INFECTION & CANCER
Stress
As we know stress is defined as " A constellation of events, consisting of a stimulus(stressor) that precipitates a reaction in the brain(stress perception) which activates physiologic fight or flight systems in the body (stress response)."
Dhabhar & McEwen, 1997. Acute stress enhances while chronic stress suppresses cell-mediated immunity in vivo: a potential role for leukocyte trafficking. Brain, Behavior and Immunity (11) 286-306.

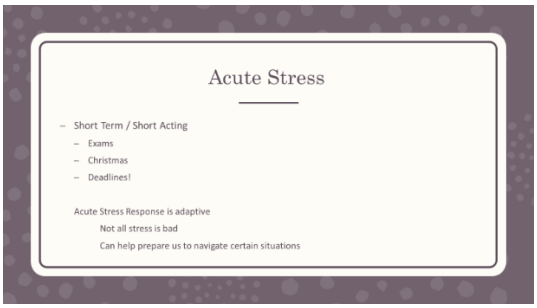

Brain-body pathways in stress
Stress
Pituitary gland
Adrenocorticotropic hormone (ACTH)
Adrenal cortex
Secretion of corticosteroids
ased protein and fat mobilization
ased access to energy storage
eased inflammation
Hypothalamus
Autonomic nervous system (sympathetic div
Adrenal medulla
Secretion of catecholamine
Increased cardiovascular respo
Increased respiration
Increased perspiration
Increased blood flow to active muscles

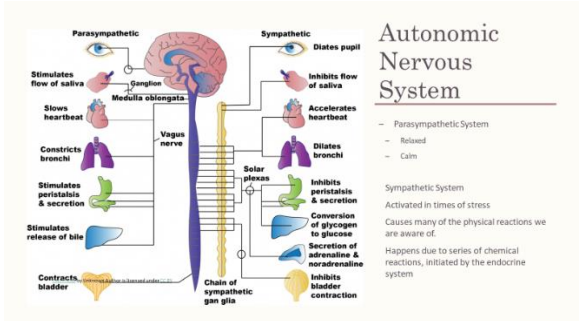

Measuring Stress
Physiological Measures
SNS Activation
Increased Blood Pressure and Heart Rate
Increased Catecholamines (adrenaline, noradrenaline)
HPA axis Activation
Increased Cortisol in blood and saliva
Reduced Parasympathetic nervous system activity (vagal withdrawal)
Reduced heart Rate Variability
Subjective Measures
Questionnaires

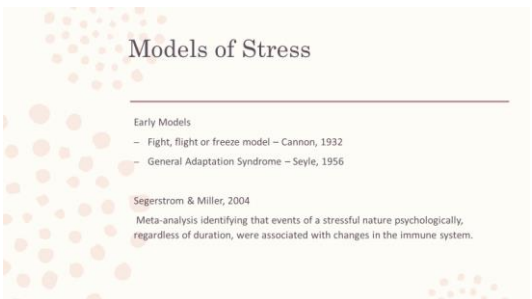

Summary
Health Psychology applies the Bio-psychosocial Model of health.
The Bio-psychosocial model of health takes into account the biological processes (Psycho-Neuro-Immunology) involved.
Next week: A closer look at the Acute Stress System.
Evaluation

Week 2

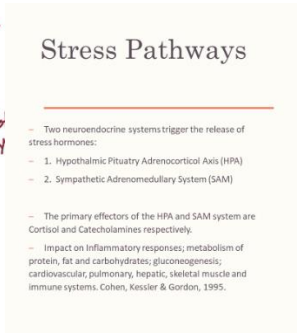

Psycho-neuro-immunology in Health Psychology
Acute Stress

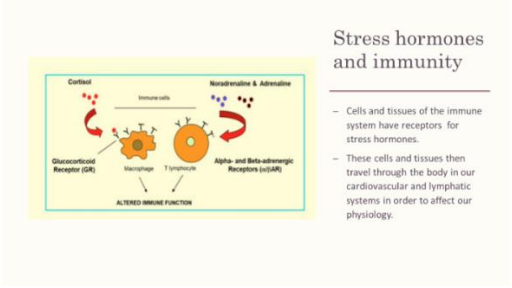

Acute Stress
Short Term / Short Acting
Exams
Christmas
Deadlines!
Acute Stress Response is adaptive
Not all stress is bad
Can help prepare us to navigate certain situations

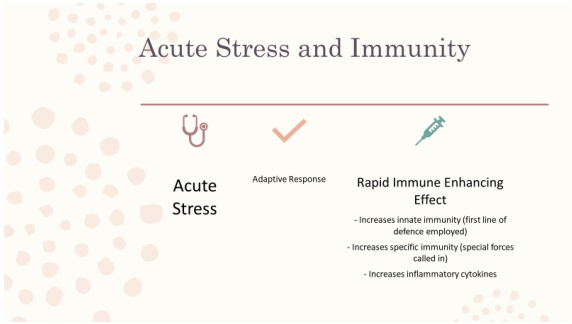

Parasympathetic
Sympathetic
Stimulates flow of saliva
Ganglion
Medulla oblongata
Slows heartbeat
Constricts bronchi
Vagus nerve
Stimulates peristalsis & secretion
Stimulates release of bile
Contracts bladder
Solar plexus
Chain of sympathetic gan glia
Dilates pupil
Inhibits flow of saliva
Accelerates heartbeat
Dilates bronchi
Inhibits peristalsis & secretion
Conversion of glycogen to glucose
Secretion of adrenaline & noradrenaline
Inhibits bladder contraction
Autonomic Nervous System
Parasympathetic System
Relaxed
Calm
Sympathetic System
Activated in times of stress
Causes many of the physical reactions we are aware of.
Happens due to series of chemical reactions, initiated by the endocrine system

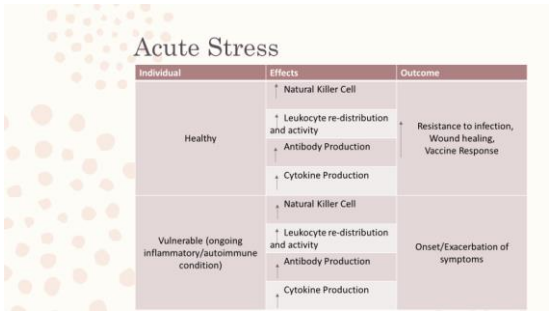

Models of Stress
Early Models
Fight, flight or freeze model – Cannon, 1932
General Adaptation Syndrome – Seyle, 1956
Segerstrom & Miller, 2004
Meta-analysis identifying that events of a stressful nature psychologically, regardless of duration, were associated with changes in the immune system.

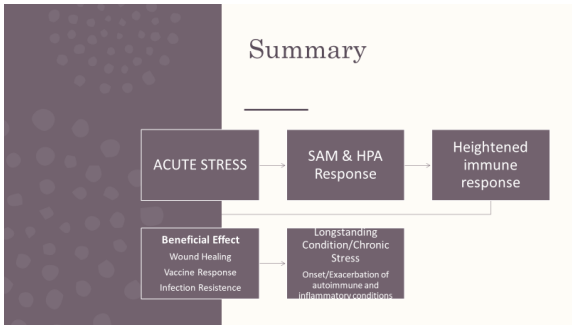

Pathways activated during stress response
Stress
Hypothalamus
Corticotropin releasing factor (CRF)
HPA axis
Adrenal-medullary system
Pituitary gland
Autonomic nervous system (sympathetic division)
sympathe nervous sy
Adrenocorticotropic hormone (ACTH)
Adrenal medulla
Adrenal cortex
Secretion of cortisol
• Increases energy from storage
• Regulates immune system
Secretion of norepinephrine
• Increases heart rate
• Increases respiration
• Raises blood pressure

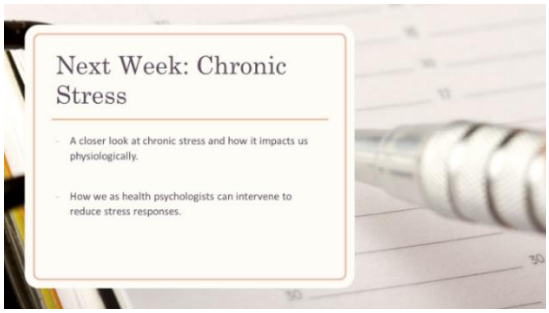

Stress Pathways
– Two neuroendocrine systems trigger the release of stress hormones:
– 1. Hypothalmic Pituatry Adrenocorticol Axis (HPA)
– 2. Sympathetic Adrenomedullary System (SAM)
– The primary effectors of the HPA and SAM system are Cortisol and Catecholamines respectively.
– Impact on Inflammatory responses; metabolism of protein, fat and carbohydrates; gluconeogenesis; cardiovascular, pulmonary, hepatic, skeletal muscle and immune systems. Cohen, Kessler & Gordon, 1995.


Stress hormones and immunity
Cortisol
Noradrenaline & Adrenaline
Immune cells
Glucocorticoid Receptor (GR)
Macrophage
T lymphocyte
Alpha- and Beta-adrenergic Receptors (α/βAR)
ALTERED IMMUNE FUNCTION
– Cells and tissues of the immune system have receptors for stress hormones.
– These cells and tissues then travel through the body in our cardiovascular and lymphatic systems in order to affect our physiology.


Acute Stress and Immunity
Acute Stress
Adaptive Response
Rapid Immune Enhancing Effect
- Increases innate immunity (first line of defence employed)
- Increases specific immunity (special forces called in)
- Increases inflammatory cytokines


Acute Stress
Individual
Effects
Outcome
Healthy
↑ Natural Killer Cell
↑ Leukocyte re-distribution and activity
↑ Antibody Production
↑ Cytokine Production
↑ Resistance to infection, Wound healing, Vaccine Response
Vulnerable (ongoing inflammatory/autoimmune condition)
↑ Natural Killer Cell
↑ Leukocyte re-distribution and activity
↑ Antibody Production
↑ Cytokine Production
Onset/Exacerbation of symptoms

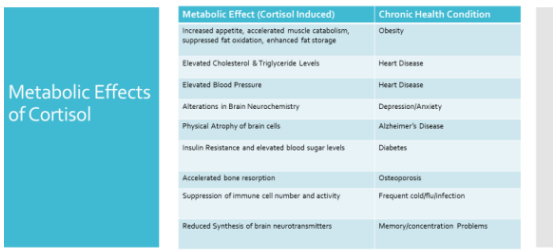

Summary
ACUTE STRESS
SAM & HPA Response
Heightened immune response
Beneficial Effect
Wound Healing
Vaccine Response
Infection Resistence
Longstanding Condition/Chronic Stress
Onset/Exacerbation of autoimmune and inflammatory conditions

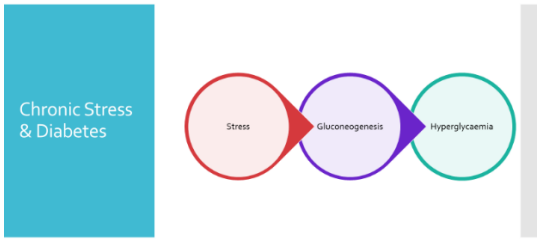

Next Week: Chronic Stress
– A closer look at chronic stress and how it impacts us physiologically.
– How we as health psychologists can intervene to reduce stress responses.

Week 3

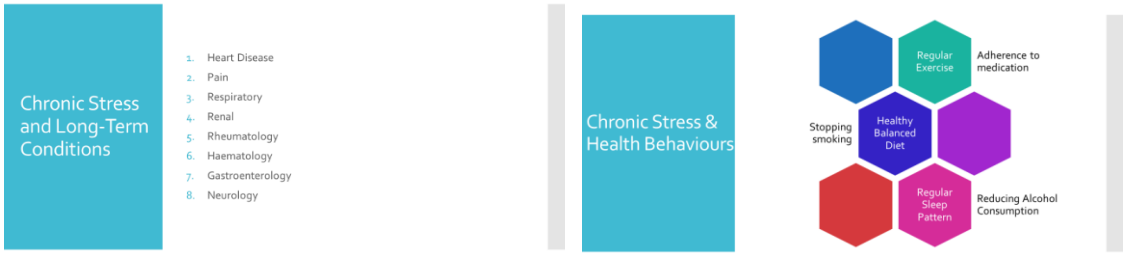

Psycho-neuro-immunology in Health Psychology
Chronic Stress
Tracy McCrossan MBPsS
Trainee Health Psychologist

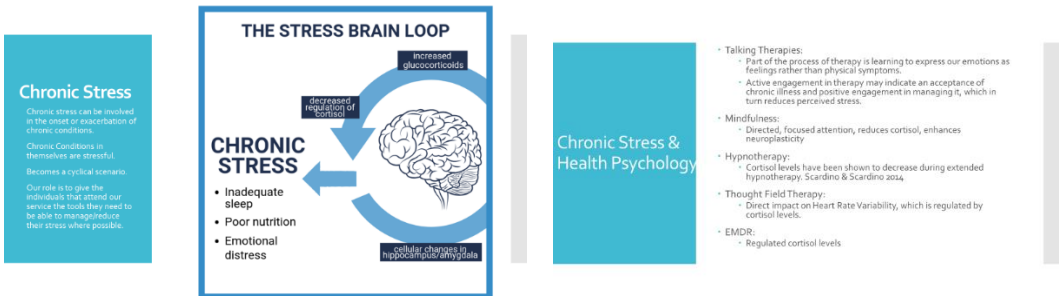

Acute vs Chronic Stress
ACUTE STRESS
ADAPTIVE RESPONSE
RAPID IMMUNE ENHANCING EFFECT
CHRONIC STRESS
MALADAPTIVE RESPONSE
IMMUNE SUPPRESSING EFFECT

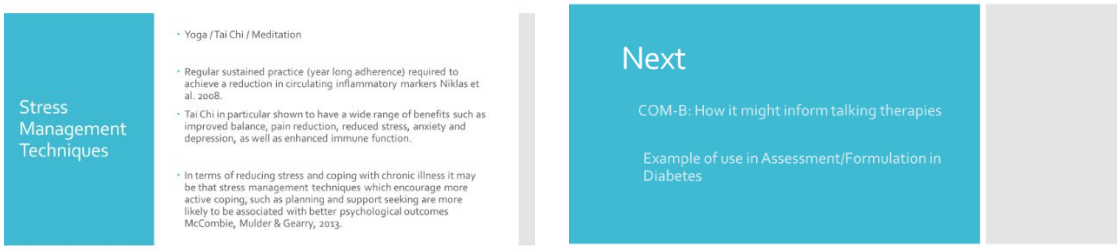

Metabolic Effects of Cortisol
Metabolic Effect (Cortisol Induced)
Chronic Health Condition
Increased appetite, accelerated muscle catabolism, suppressed fat oxidation, enhanced fat storage
Obesity
Elevated Cholesterol & Triglyceride Levels
Heart Disease
Elevated Blood Pressure
Heart Disease
Alterations in Brain Neurochemistry
Depression/Anxiety
Physical Atrophy of brain cells
Alzheimer's Disease
Insulin Resistance and elevated blood sugar levels
Diabetes
Accelerated bone resorption
Osteoporosis
Suppression of immune cell number and activity
Frequent cold/flu/infection
Reduced Synthesis of brain neurotransmitters
Memory/concentration Problems


Chronic Stress & Diabetes
Stress
Gluconeogenesis
Hyperglycaemia


Hyperglycemia and Impaired Immunity
Immune Response in Normal Circumstances
Immune Response with High Blood Sugars
Chronic Stress & Cancer
Studies have linked psychological factors such as stress, chronic depression, and lack of social support to the incidence and progression of cancer.
Not fully understood, however, neuroendocrine pathways and the Sympathetic Nervous System are all believed to play a role.
In a study conducted in 2015, it was identified that chronic stress "restructures the lymphatic networks within and around tumours to provide pathways for tumour cell escape". Caroline et al. 2016
Also need to consider the impact of stress on increased lifestyle risks.


Chronic Stress and Long-Term Conditions
1. Heart Disease
2. Pain
3. Respiratory
4. Renal
5. Rheumatology
6. Haematology
7. Gastroenterology
8. Neurology
Chronic Stress & Health Behaviours
Regular Exercise
Adherence to medication
Stopping smoking
Healthy Balanced Diet
Regular Sleep Pattern
Reducing Alcohol Consumption


Chronic Stress
Chronic stress can be involved in the onset or exacerbation of chronic conditions.
Chronic Conditions in themselves are stressful.
Becomes a cyclical scenario.
Our role is to give the individuals that attend our service the tools they need to be able to manage/reduce their stress where possible.
THE STRESS BRAIN LOOP
increased glucocorticoids
decreased regulation of cortisol
CHRONIC STRESS
Inadequate sleep
Poor nutrition
Emotional distress
cellular changes in hippocampus/amygdala
Chronic Stress & Health Psychology
Talking Therapies:
Part of the process of therapy is learning to express our emotions as feelings rather than physical symptoms.
Active engagement in therapy may indicate an acceptance of chronic illness and positive engagement in managing it, which in turn reduces perceived stress.
Mindfulness:
Directed, focused attention, reduces cortisol, enhances neuroplasticity
Hypnotherapy:
Cortisol levels have been shown to decrease during extended hypnotherapy. Scardino & Scardino 2014
Thought Field Therapy:
Direct impact on Heart Rate Variability, which is regulated by cortisol levels.
EMDR:
Regulated cortisol levels


Stress Management Techniques
Yoga / Tai Chi / Meditation
Regular sustained practice (year long adherence) required to achieve a reduction in circulating inflammatory markers Niklas et al. 2008.
Tai Chi in particular shown to have a wide range of benefits such as improved balance, pain reduction, reduced stress, anxiety and depression, as well as enhanced immune function.
In terms of reducing stress and coping with chronic illness it may be that stress management techniques which encourage more active coping, such as planning and support seeking are more likely to be associated with better psychological outcomes McCombie, Mulder & Gearry, 2013.
Next
COM-B: How it might inform talking therapies
Example of use in Assessment/Formulation in Diabetes

Week 4


Psycho-neuro-immunology
COM-B


COM-B
Behaviour Change

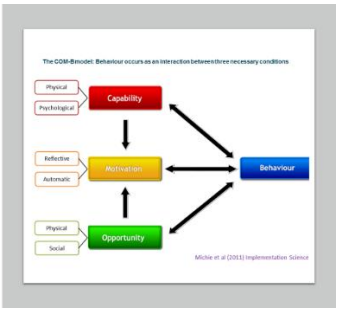
Limitations

1. Limited explanation of health behaviour
2. Overlapping constructs
3. Context

(Michie et al, 2014)

COM-B

- Addresses lack of integration
- Simple starting point
- Interacting system



Capability

An individual's psychological and physical capacity to engage in the activity concerned

- Knowledge and skills
- Psychological Mindedness
- Physical Strength

Opportunity

Factors that lie outside the individual that make the behaviour possible

Physical:

- Time, location, resources

Social:

- Ecological Systems: SES, culture, access to healthcare

Motivation

Mechanisms that activate or inhibit behaviour.

Reflective Motivation:
Making plans, analytical decision-making and evaluating

Automatic Motivation:
Habitual processes, emotional responding, desires, impulses, inhibitions

COM-B at Assessment

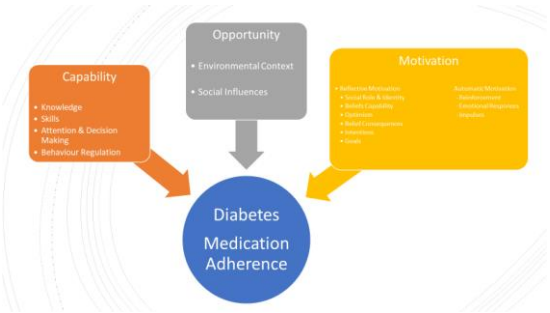
IDENTIFYING SMART GOALS

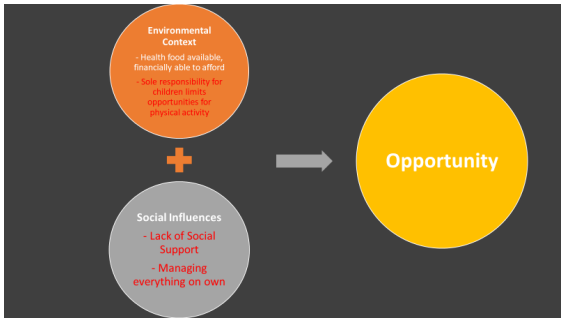
ASSESS OBSTACLES TO CHANGE

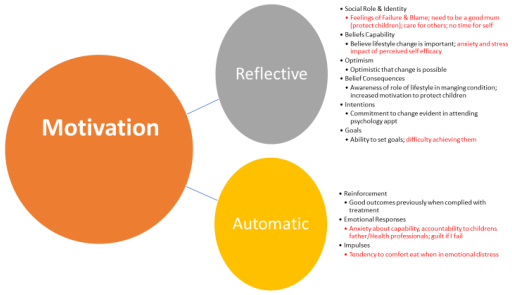
INFORM INTERVENTION

Case Example

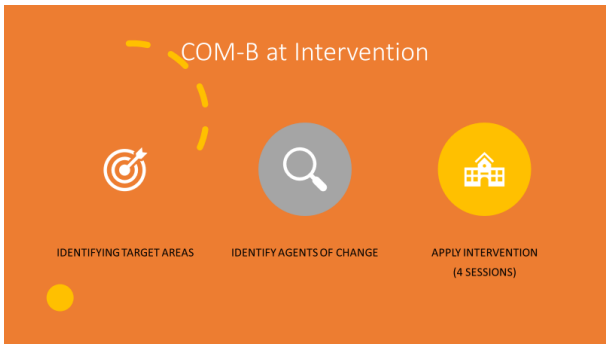
Type 1 Diabetes Case



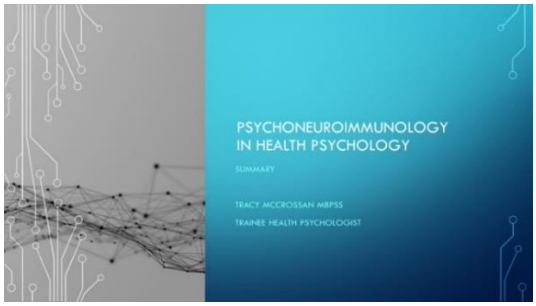



Motivation
Reflective
Automatic
• Social Role & Identity
• Feelings of Failure & Blame; need to be a good mum (protect children); care for others; no time for self
• Beliefs Capability
• Believe lifestyle change is important; anxiety and stress impact of perceived self-efficacy
• Optimism
• Optimistic that change is possible
• Belief Consequences
• Awareness of role of lifestyle in manging condition; increased motivation to protect children
• Intentions
• Commitment to change evident in attending psychology appt
• Goals
• Ability to set goals; difficulty achieving them
• Reinforcement
• Good outcomes previously when complied with treatment
• Emotional Responses
• Anxiety about capability, accountability to childrens father/Health professionals; guilt if I fail
• Impulses
• Tendency to comfort eat when in emotional distress

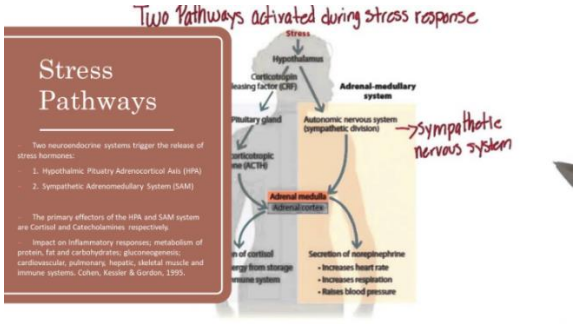

COM-B:
Assessment &
Intervention
Assessment and formulation using the COM-B, highlighted specific areas to address which informed the intervention.
Capability
Opportunity
Motivation


COM-B at Intervention
IDENTIFYING TARGET AREAS
IDENTIFY AGENTS OF CHANGE
APPLY INTERVENTION
(4 SESSIONS)

Week 5


PSYCHONEUROIMMUNOLOGY
IN HEALTH PSYCHOLOGY
SUMMARY
TRACY MCCROSSAN MBPSS
TRAINEE HEALTH PSYCHOLOGIST

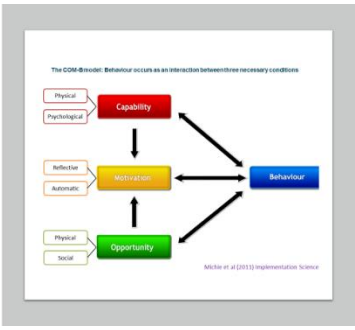

The biopsychosocial model describes interactions between psychosocial and biological factors in the aetiology and progression of disease. How an individual interprets and responds to the environment determines responses to stress, influences health behaviours, contributes to the neuroendocrine and immune response, and may ultimately affect health outcomes.
Health psychology interventions are designed to modulate the stress response and improve health behaviours by teaching individuals more adaptive methods of interpreting life challenges and more effective coping responses.


Two Pathways activated during stress response
Stress Pathways
Two neuroendocrine systems trigger the release of stress hormones:
1. Hypothalmic Pituatry Adrenocortical Axis (HPA)
2. Sympathetic Adrenomedullary System (SAM)
The primary effectors of the HPA and SAM system are Cortisol and Catecholamines respectively
Impact on Inflammatory responses; metabolism of protein, fat and carbohydrates; gluconeogenesis; cardiovascular, pulmonary, hepatic, skeletal muscle and immune systems. Cohen, Kessler & Gordon, 1995.
Stress
Hypothalamus
Adrenal-medullary system
Autonomic nervous system (sympathetic division)
sympathetic nervous system
Adrenal medulla
Adrenal cortex
Secretion of norepinephrine
- Increases heart rate
- Increases respiration
- Raises blood pressure


How Inflammation Affects the Body
Chronic Stress & Inflammation
– When we think of inflammation, we often think of the pain conditions, the rheumatoid arthritis, fibromyalgia etc.
– Inflammation affects many of our systems and as such its effects are much further reaching than we sometimes realise.
– In chronic stress the inflammatory system is highly active and has the potential to cause a number of different symptoms, therefore addressing stress from the outset can be key to addressing physical symptomology as well as reducing the emotional burden.

COM-B

- Addresses lack of integration
- Simple starting point
- Interacting system



Chronic Stress & Health Psychology

- Thorough Assessment
- Psycho-education regarding stress (generally)
- Psycho-education regarding stress (Condition Specific)
- Talking Therapies
  - Evidenced Based;
  - Mindfulness;
  - Hypnotherapy;
  - Thought Field Therapy;
  - EMDR.

REFERENCES

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LINKS

- https://www.youtube.com/watch?v=sabuBhSIffI
- https://www.youtube.com/watch?v=YCsyTd29i9Y&t=43s

Appendix 2: Student Evaluation Forms

Western Health and Social Care Trust

LIVERPOOL JOHN MOORES UNIVERSITY

Teaching Session 1 Feedback Form: Psychoneuroimmunology in Health Psychology

The session today refreshed my understanding of the topic?

Strongly disagree 1 2 3 4 (5) Strongly Agree

Was the content interesting?

Very Uninteresting 1 2 3 4 (5) Very Interesting

Did you find the session useful?

Not Useful 1 2 3 4 (5) Very Useful

The material was presented in a manner that facilitated understanding?

Strongly disagree 1 2 3 4 (5) Strongly Agree

What are the most memorable pieces of information you will take away from this session?

The viral role psychology plays in a person's medical recovery – "medical support keeps me alive ... psychological support that enables me to live" – poignant quote!

Would you like to add anything about the coverage or focus of the lecture?

NO - excellent Introduction.

Is there anything else you would like to say about the session?

The Layout x video were very ~~was~~ engaging x informative!

Western Health and Social Care Trust

LIVERPOOL JOHN MOORES UNIVERSITY

Teaching Session 2 Feedback Form: Psychoneuroimmunology in Health Psychology: Acute Stress

The session today refreshed my understanding of the topic?

Strongly disagree 1 2 3 4 (5) Strongly Agree

Was the content interesting?

Very Uninteresting 1 2 3 4 (5) Very Interesting

Did you find the session useful?

Not Useful 1 2 3 4 (5) Very Useful

The material was presented in a manner that facilitated understanding?

Strongly disagree 1 2 3 4 (5) Strongly Agree

What are the most memorable pieces of information you will take away from this session?

found it very interesting to think about how we as clinicians can impact our patients physiologically as well as psychologically, in terms of stress reduction.

Would you like to add anything about the coverage or focus of the lecture?

No - great session!

Is there anything else you would like to say about the session?

I always knought about the impacts of Chronic stress, but this session informed me about the impact of acute stress on our patients with long-term condition!

Appendix 3: Peer Review

This teaching session was a valuable addition to ongoing CPD for staff. Whilst staff were familiar with most of the information there was a focus on returning to the basics of stress and its impact on physical health and illness. We as professionals often assume our clients have knowledge of the basics of stress and its role in physical and mental health and in reality our experience tells us this is simply not the case. As a result of these teaching sessions I have found myself focusing on this psycho education element of sessions for a little longer than previously which has had a noticeable impact on therapy.

Tracy's presentation style was relaxed yet organized in a methodical way with each session naturally linking on to the next. She opened the presentation up to the floor for questions and indeed was able to further add to subsequent sessions in order to address these.

Of note was Tracy's ability to adapt the teaching delivery using Zoom in light of Covid 19. She remained at ease throughout which aided delivery of content and created a comfortable dynamic which facilitated the audience's ability to understand the content.

Teaching & Training Diary

This reflective diary offers insights on a number of teaching experiences throughout the course of the Professional Doctorate in Health Psychology which demonstrate my professional development over the previous two years of experiences in the teaching competency. It is supplementary to my teaching and training case study which documents in detail a teaching experience with a group of 10 healthcare professional (psychologists). Throughout this diary there are numerous references to the 8-week pain management programme (PMP), which I deliver on one of our hospital sites. It is important to note that while the same programme is delivered on a rolling basis throughout the year, the group of participants change for each programme and even within a programme participants engagement and interaction change which impacts on all other aspects of the programme including my delivery.

The Professional Doctorate in Health Psychology began on the 26th January 2019, therefore I have begun my reflections following this point despite the fact that there were at least 2 other teaching experiences in January 2019.

As mentioned in the introduction I deliver the 8-week pain management programme (PMP) on one hospital site, with the support of a physiotherapist and occupational therapist. I have been involved in the planning and delivery of this programme for approx. 13 years, having inherited it as a pilot programme from the previous psychologist. As you might imagine, it have gone through several iterations at this stage, therefore the majority of my entries regarding the PMP will focus more on delivery rather than development of the sessions. In delivering the PMP I am present for all 8 sessions of PMP and deliver specific psychology talks during some sessions, while observing and inputting on a less formal basis in the other sessions. The pain management programme highlighted in this first diary record was in its 2nd week.

29th Jan 2019 PMP

I delivered the stress management talk to 12 patients today. I feel it went well, the group was quiet (still getting used to each other and us) although there was a lot of nodding, with a few avoiding eye contact (felt there was a recognition of how stress may impact their own scenarios). The physiotherapist has recently joined our team and reported feeling a bit overwhelmed at the detail in which we explored the stress aspect of pain. This was a shock as I felt that over the past few years, I had revisited this talk on a number of occasions and reduced the information to the bare essentials. On further discussion, what the physiotherapist had noticed wasn't the level of information delivered on the slides but the level of discussion it sparked, which I facilitated throughout the talk. Having previously delivered the 'Moving with Pain' programme, which has a similar information content, she was familiar with the information however felt that it was not as fully explored as it was in PMP and attributed that to the different professionals involved. So, while she was judging the programme and potentially my delivery, it was in a more positive way than I had anticipated at the first session. It was also useful to have her share her perspective on what was delivered and how it was received by the participants. As I mentioned already I had revisited this talk on a number of occasions and had reduced the content, however, from her evaluation the information that was delivered appeared to be enough to allow the participants to apply it to their own scenarios and identify how it was impacting on their pain pathway.

5th Feb 2019 PMP

Occupational therapy (OT) talk today, great to have a bit of a breather and be able to observe. While I enjoy delivering the PMP, I feel there is an element of putting on a performance when delivering a talk. Therefore, when another professional is delivering a talk, I find it interesting to become more of a participant, observing the non-verbal communication within the group. This allows me to offer insights that connect both the current talk and the content from previous sessions and relate it to everyday scenarios. Today's talk was the 'Introduction of goal setting', it was easy to see that patients are starting to become more engaged and comfortable in the room. A wide range of goals were identified, although perfectionistic tendencies were starting to show for some.

Today's participation in PMP allowed me to identify areas that require more focused psychological attention that I can pick up on during my next session.

12th Feb PMP

OT follow up talk, pacing. The OT assessed the goals set last week, successes/stumbling blocks, explained rationale for pacing. There appears to be a recognition starting to dawn on some that there are potentially things they can change both practically and in terms of their thinking that might assist them in managing their pain. Again, the opportunity to observe was extremely useful and allowed me to identify two participants that I felt required some extra input. As the session progressed I was able to have some individual contact with a few of the patients, in particular the two I had identified as possibly needing some additional extra input. These unplanned moments of individual contact within the PMP can be key for some of our participants as they allow them to address issues that they may not be totally comfortable to bring up in the bigger group. Having these conversations confidentially, allows me at a future point in the group to address these issues at the group level and normalise, as well as problem solve them with the other participants.

19th Feb PMP

So, I was back to delivering a talk today - Managing Mood – which is closely linked into the stress management and goal setting & pacing talks. I felt there was a heightened awareness of how mood might impact on pain rather than just pain impacting on mood. Two of the participants were quietly tearful at times throughout talk, and I made a point of a having a quick chat with them before they left. They were able to recognise themselves in the talk and were upset about various situations in the past – reassured that now they were able to identify their role and the role of the pain they would be able to manage similar scenarios in the future differently – feeling empowered. This is often a difficult talk for many but an extremely useful one – I felt the penny has dropped today for most of the group, I look forward to the next session feeling energised, as, in my experience this is where the real changes start to happen.

26th Feb PMP

Today we explored flare ups and set backs, as this was the last day (shorter programme this time, no physio talks as she was observing this first programme/also no pharmacy talk as the pharmacist was unavailable). Final observational assessment, 7 of the 11 participants have started to make the changes required and manage their pain differently, the other 4 possibly require more time or may be more fixed in their thinking (we do have some participants who have been used to the paternalistic healthcare system where they feel it is someone else's job to fix them). 1 participant in particular was quite challenging this morning, however other members of the groups were able to share their experiences and use these to address the issues identified, which leaves me doing a secret 'fist pump' inside. I'm exhausted but have a great sense of achievement in completing this group. Having received participant feedback I also asked for some feedback from [redacted], the physio, she reported feeling "shell shocked" at the depth we explore in the group in terms of the psychological component. She described this as being so useful but not what she's familiar with from a physiotherapy point of view. This leaves me feeling an immense sense of pride, as having started delivering this programme some years ago, initially with another psychologists slides and having developed this programme with my own information and refining that over the years, it is encouraging to see another health professional recognise the benefits of it.

Having completed the previous pain management programme there are a few weeks now where I can look at the evaluation forms. I will also use this time to work with the physiotherapist on what has previously been covered by physio and how she would like to develop that with her own style while remaining consistent to the group.

4th Mar PPI Focus Group

Our trust covers three hospital sites and traditionally the pain management programme has been delivered on one site only, with participants having to travel to access it. More recently we have been able to secure appropriate accommodation on one of the other sites and now deliver PMP over two sites, this has created an inequality in service

delivery and as such we are conducting a Personal & Public Involvement (PPI) focus group to explore the demand for PMP on this site. It was an extremely interesting focus group containing 2 very strong personalities, which were difficult to contain at times. We gathered lots of useful information regarding the provision of Pain services in this area, and have lots to feedback to PPI team. I am glad that I was not conducting this focus group on my own though as I really appreciated the support of my colleague when dealing with the strong personalities in the room. Even just from the perspective of being able to evaluate what had been said once the group was over, I think if I had been on my own I might have doubted whether or not I had handled it as well as I had.

5th Mar PMP

A new PMP group beginning this week, with the physiotherapist now ready to start inputting to the sessions. This is a smaller group than the last with just 10 participants starting, they all appear keen to engage with each other from the outset, going by the chatter in the room as we set up the projector (not always the case). I'm aware of feeling more relaxed as a result of the interaction between the group, feel the pressure is off a little, possibly less work for me to do to engage everyone?! With most pain management groups, the initial session can be particularly quiet as everyone begins to get to know us and the rest of the group. Every now and again, a group will be like this one and be particularly talkative from the outset and there is something refreshing about this as it signals that they are perhaps more open to discuss their own situations in relation to their pain which means that they are already engaged and I don't feel like I have to 'sell' the benefits of the group, they've already engaged with the purpose of the group from the outset, which is really encouraging.

19th Mar PMP

As with last week, there is a relaxed feel about this group which I am particularly grateful for today. I spent most of yesterday, along with my colleagues in the hospital, as our secretaries son was taken off life support. He had tried to take his own life and despite best efforts of the hospital staff they were unable to save him. In an ideal world todays

session would have been cancelled, however, the task of contacting 10 patients with no secretarial support at late notice seemed too much. While I feel I'm not fully able to give my all today I delivered the stress management talk while feeling like a hypocrite (I'm certainly not managing my stress well today). Despite that the talk went well, with lots of personal examples from most of the patients. This level of shared experience feels extremely powerful and I am grateful for it, particularly today. I feel really privileged to be part of the facilitation for groups like these, that with a little guidance and steering effectively manage themselves. Its almost as if they had all the information, but just needed to be together in the one room to be able to piece it together properly. I definitely need to take a closer look at our assessment process with this group to see if there is something in particular that makes this group more read/receptive for this information.

26th Mar PMP

It feels like I'm not really needed in this particular group. I covered managing mood today, 1 member was a little quieter than the others, and two of the group recognised this and made sure to engage a little more with them at tea break. This seemed to do the trick and they were more engaged thereafter sharing an insight into what was going on for them. Like I mentioned last week I wish I had the secret formula we followed for selection this time round – if all groups were like this, pain management would naturally make its way around the world without any groups/programmes.

2nd April PMP

Observation only, as OT delivered the talk today. This is definitely a unique group, there is great energy in the room - I have a feeling that this will be one of those groups that keeps in touch after the programme is finished.

9th April PMP

Again OT delivering today, she has changed her talk slightly, and I felt it was a bit wordy, it seemed to work ok with this group although I'm not sure how well it will work with a

less engaged group. Will discuss with supervisor, feel I might need to highlight the wordiness with her as she's not long in post either and still finding her feet.

16th April PMP

I feel that this group being small compared to the previous group might have worked in the patients favour, allowing them greater space to explore the nuances of what is important/difficult for each individual, therefore their pain plans were more tailored to their specific situations and possibly more effective as a result. It could also just be that this particular group were just more ready, for whatever reason, for the information we were delivering and had nothing at all to do with the size of the group.

18th April Pulmonary Rehabilitation

This group were poorly engaged. Although, they had just finished the exercise component of the programme, so they were possibly tired?! 2 patients were happy to feedback a little more today than they were at the last session in January and as a result I feel the group generally got more from the talk. As I have mentioned in my case study my experience of delivering group-based programs has led to an understanding that didactic techniques rarely engage participants. Therefore, a more Socratic delivery generally tends to offer greater learning, however, it can be painful at times like this where the majority of the group are not keen to engage. For me, psychology involvement in this program, while important to the nurse running the program, is only introduced as an 'add-on'. This is difficult from a number of perspectives; 1. Delivering 3 sessions of this program, means that psychology are slotted in where possible, so from the psychologists point of view there is no sense of the individual patients and what is important to them in managing their condition; and 2. The patients possibly have no prior contact with psychology and are not as willing to engage with a professional that is just dropping in every now and then. So, while some patients do benefit from the input of a psychologist in this program, I feel that to increase the effectiveness of this program from a psychological perspective, there needs to be psychology input from the outset.

18th April PMP Information Session

This was a large group, and as a result the room felt congested (plan to reduce numbers for this room again). Lots of patients with similar diagnoses, perhaps we need to consider condition specific groups in the future? On second thoughts, possibly better with mix of conditions as I think working with one specific condition could be tough going. Most are keen to approach pain management in a new way, however a few are not so sure but "will give it a try". Glad for the open-mindedness at this stage and plan to explore any concerns or reluctance further at the individual assessment sessions. It's always exciting, yet nerve wracking as a new group of potential patients come through for the information session, I'm never sure, despite the referral letter just what to expect. While some resistance to a new strategy to manage pain can be expected, there are occasions where patients are highly resistant, and these can be difficult to manage.

30th April PMP

The physiotherapist took the session today for first full talk, she has done some range of movement exercises with this group and has now explored the differences of acute vs chronic pain. She obviously has a different style to previous physio, rate of speech a little fast but perhaps she's nervous! Good engagement from the group though. Discussion with the physio following the group who stated that she felt her talk was maybe too long, I highlighted that there was great interaction from the group with relevant questions raised. I also highlighted that this was the first talk she had delivered in the pain management programme and that it was only to be expected that the talk may not be exactly as she wanted it to be on the first occasion and as the programs progressed it was likely to be revised on a number of occasions.

7th May PMP

This group could easily have managed the shorter number of sessions (like we had at the last program) as they've been so clued in from the outset. One of the difficulties of groups – you never know what you might get in terms of group cohesion. Although, having introduced the information sessions, followed by the individual assessments for

those that are interested, the groups have been more ready to engage in the programme. How they will all interact together however is harder to assess from the outset.

14th May PMP

Last session for this group, addressed flare ups, don't feel it was as necessary with this group as with others, as they appeared to have picked it up throughout the various talks delivered in the program, so encouraging.

24th May PMP Information Session

Again, a fairly big group for an information session, although we had access to the bigger room today which makes it more manageable. This group appears to have a few more vocal patients in this group, some who appear quite resistant and are also exhibiting lots of pain behaviours. Most appeared to be engaged, although as mentioned a few looked quite cynical. Not the easiest session ever, I feel exhausted afterwards and the physiotherapist just looked at me with wide, shocked eyes. While she has worked with chronic pain patients before, I'm not sure she has ever fully entered into any real discussion about the long term management of it, or maybe she has and its just a 'safety in numbers' type of thing in a group setting that allows patients to verbalise their resistance to alternative ways to manage their pain. Poor [redacted], its definitely a learning curve for her, but I am glad I don't have too many booked in for this afternoon.

25th June PMP Info Session

Again a good sized group, possibly not as engaged as the last one despite some challenging comments/queries, glad that the OT and Physio were there to help address some of the queries. Not convinced that there will be great uptake for 1:1 assessments from this group, but that might not be a bad thing either. I think this would be a really tough group to work with, but in many ways it's a great reminder of the complexities of group work. I really enjoy working with the pain management programme group, and that's partly because I'm pretty much in control of it from the information session forward, so I have a fair idea of what I'm going to be dealing with, as opposed to the

Pulmonary Rehab group where I just 'pop in' to deliver specific sessions. But for the most part if you have been able to engage a group from the outset, you have a much more receptive audience to begin with, but you also have a wealth of user experience within that group and once a topic is identified and opened for discussion, a lot of the time the actual work of the group is done by the participants themselves and we as health professionals are merely facilitating that. I can't speak for my colleagues but I know when I see that I have an immense sense of pride, even though my input has been minimal. Those are the groups I go away from feeling energised and refreshed, however there are not always like that and I suppose for me its important to be mindful of the groups that are reluctant to engage, they require a lot of input, and a lot of energy and I know at the end of those I go away feeling drained. On those days, when I step into the car to drive back to my base, I am already exhausted before the drive and am praying that one of my afternoon patients will cancel – which is not a great place to be.

23rd July Pul Rehab

Interesting group – 1 very engaging character. I recognise them from a previous pul rehab course, but they're much more lively on this occasion. They were really helpful in making the other participants feel at ease and talk more openly about the issues that they're facing emotionally as a result of their conditions. I'm still frustrated though, I would like to change our involvement in this group, I'll have to speak to one of my colleagues who takes the lead with the respiratory team about making changes here.

30th July Pul Rehab

As last week, better group involvement than previously, 2 patients spoke with me individually after the talk, as they were keen to see how they might access 1:1 psychology service. Details given and staff notified that referrals need to be followed up. I'm glad they felt able to approach me and request further information about accessing psychology.

1st Aug Pyrography Workshop

So this is a completely different teaching session for me and on the face of it has little to do with health psychology, however, it has been requested that I deliver a 'craft workshop' and evaluate it in some way to identify if engaging in a craft session might be beneficial for health (Physical and emotional). As a result it is really disappointing that there has only been 3 participants signed up for the class – there was potential to have up to 12 participants across the day, however, these spaces have not been filled. 1st learning point, never leave the advertising and recruitment up to someone else! I'm not even sure if this will be enough to fulfil my consultancy competency now, I thought I was already stretching things with evaluating one class, never mind one very small class. Having taken the time to think about how I might teach the skill of pyrography, I have a few plans in place and have brought different types of wood, some with designs already drawn on them, some that are plain and depending on the participants can de developed from their own ideas or from some of the ideas in the books I have brought. I also have my assessment tools and need to introduce those early, but in a non-threatening way. The three participants that turned up all have physical mobility issues and one also had some emotional difficulties. I don't think that if I tried to recruit these participants I could have but they will certainly add a layer to my evaluation that I hadn't been expecting, and they were more than happy to complete the assessment measure – so I'm slightly more encouraged. As we started to talk about how we would approach the class, I realised that they had all been involved in some form of crafting before but never pyrography and as a result they were all keen to draw their own designs and then work from there. One of the participants had a visible shake in her hand and appeared to tire easily, So I was mindful to offer as much support as possible and built in more short breaks than I had intended. This allowed her to take a break without feeling different from the others and is something that one of the other participants thanked me for at the end of the session. For me it was a safety concern as much as anything else, using a hot, electrified pen while shaking or fatigued is not advisable, however, I felt to refuse her would have knocked her confidence and embarrassed her, it would also have potentially left me with no class as all three were there together!! As the class finished everyone was in good spirits – the ladies were happy with their pieces and I was really pleased with how well it had gone, despite my earlier disappointment – I will have to discuss this further with my supervisors to see if they think its worth using this for my

consultancy piece – it was certainly a big learning moment for me, I will definitely do things very differently in the future when it comes to consultancy!

4th Sept Diabetes UK Support Group

This is a group that we meet with at least once a year. It is a community based group, however they invite us as psychologists to talk about our service and the ways in which we might be of assistance to anyone struggling emotionally with diabetes. It was a large group tonight, approx. 16 in total, only 7 at last session. There appeared to be a few new members, who engaged well with the talk, and were keen to know about the impact of diabetes on mood and how this might be addressed. Advised on referral pathways and had a few individual conversations prior to leaving with participants who had specific queries yet were not keen to address these in the larger group format. I definitely felt a little vulnerable with the size of the group, which is run by retired GP, is delivered in the community, outside of working hours. I'm always fearful that someone will ask something that I'm unable to answer. There can generally be a lot of medication specific questions which I generally refer to the GP, however he's retired sometime so not up to date with new changes. I think that similar to the issues encountered in my consultancy, with recruitment and knowing some basic details about the participants prior to the group, I will be mindful when this group is requested again to ensure I have more details prior to accepting and potentially recruit a member of the community diabetes nursing team to support me in this.

10th Sept PMP

So we are starting a new PMP today, however, both emotionally and physically I feel completely drained. The last few weeks have been quite difficult, my colleague and supervisor have been off on AL, leaving only me in the department, which is not normally an issue as there are other clinically qualified staff on the other site that I can call on if I have concerns regarding patients. However, we have temporary secretary covering the [redacted] leave of our normal secretary [redacted]. As a result feel ready for AL myself, rather than starting a new PMP group. The group was also tough, all participants were new to us and each other – and

everyone is a little cautious of each other. I'm also aware of my own emotional wellbeing at the minute and know that feeling drained may have me perceiving this group as tough when actually it may be fairly typical. The ice breakers revealed someone with tlnwl – which we addressed in group and then individually following group. As we finished this session I felt that we had addressed everything appropriately and have contracted with the individual to follow up with both them and their GP ahead of the next session and re-assess whether continued participation in the group is beneficial at this time or if we may need to postpone until mental health addressed.

17th Sept PMP

1 patient postponed to next programme following the issues revealed at the 1st session. 2 CNAs. The group was well reduced in numbers from last week, however, all with valid reasons. Stress management was addressed, with some engagement from a few of the members, and recognition in the other faces, just not so ready to share with the group yet. Unsure about how well this group might gel. The better the group cohesion, the easier I find they are to engage in discussion which helps aid understanding, and as I think I've said previously, the easier my job is too.

24th Sept PMP

Managing mood talk. Struggling to engage this group, energy is low – could be the group/could be me and how I'm feeling at the minute. With my confidence low/energy low I feel it could be impacting on the group. I've talked it through with the OT and physio though and they seem to believe it's just a quieter group generally and they haven't really noticed me being different in this group. I'll be interested to see if the OT taking the lead will change things next week.

1st Oct PMP

The OT struggled to generate some energy in the room around goal setting today. I feel a bit more reassured now that it wasn't just me being low in energy/confidence that had an impact on the group. I definitely think this is a topic to bring to supervision though, this is twice this year, I have been delivering PMP when I really feel I shouldn't have

been, however the fact that me not delivering it means it would be cancelled and have to be fitted in at another time adds a pressure to keep going.

8th Oct PMP

So today the OT had the main talk again and covered pacing. There were lots of obstacles presented to goal setting and pacing, and both myself and physio stepped in at different times to try and assist, or explain things from a different perspective, which definitely helped the OT, but I'm not sure it did much to change the opinion of patients though. The OT reported feeling shocked after the session, she couldn't believe how tough it was at times and was grateful that we were there to take some of the pressure from her. I'm not sure what was different in our assessment of these patients for PMP but they're definitely not as ready for change as I would have liked them to be. Again, I'm reassured that it wasn't just my mood on those first sessions that was impacting the group but I can feel the physio's nerves increase as she is due to deliver next weeks talk.

15th Oct PMP

The physio got delivered what is generally a tough session, educating participants on the differences between acute vs chronic pain. It was definitely no easier with this group and not a comfortable session for participants or staff, this group are resistant to considering alternative management styles or their own ability to manage pain, which I thought we had been quite clear this programme was all about, at the information session, assessment and again on the 1st day of the program. Exhausted, don't even know what to write!

22nd Oct PMP

Another frustrating session with this group, they all described lots of issues with sleep, between the physio, OT and myself we addressed all issues highlighted from a range of perspectives, the group remained silent throughout, with stony faces. At this point I am starting to wonder why they continue to attend when they don't seem to want to know what we have to say and don't appear to be getting anything from the sessions. I'm at

a loss to figure out how we could have addressed this group differently to make it run any better, or aid engagement.

29th Oct PMP

Today was the last session with this group – thank goodness. While the issues I was having at work with the temporary secretary have improved, this group has been really tough (I can't remember ever having such a difficult group) and it hasn't helped with my confidence, given that it had already taken quite a knock – supervision required for sure, possibly for all the team, OT and physio too.

19th Jan 2020 The role of health psychology in PMP

As a result of having a new physio in the pain management programme, awareness has been raised within the core physio team about the role of health psychology in pain management. The PMP pysio has a split post, working 2.5 days in PMP and 2.5 days in core physio and has obviously been sharing her experience of PMP and the role of psychology with other member of her team. As a result I have developed a session lasting approx. 45 minutes (the physios are restricted in terms of time) exploring the role of health psychology in pain management. The physio department already deliver a Moving with Pain prog, however had noted the increased complexity of patients in recent times and were keen to know how they might address this complexity. The group were receptive to the information presented and keen to follow up at a later date. I think delivering this session also highlighted the role of PMP which they may not have fully considered before, believing that their Moving with Pain programme was similar. While the initial request was for information regarding how they might manage more complex cases, I feel they probably wanted more clarity around PMP generally and as a result will likely increase referrals to the programme.

4th Feb PMP

New programme, starting out with 14 participants. 4 standout personalities in this group, 3 with exaggerated pain behaviours, 1 with heat blanket who needs a plug. The second needed assistance into the room by partner, and the 3rd arrived a half hour late

and took considerable time to get settled in the room. As the group progressed, the 3rd who arrived late appeared confused, asking lots of questions, tending to go off topic and required a lot of management to draw back to the topic at hand. I spoke with them individually at the end of the session, explored how they felt the group had gone – they admitted that they found it difficult to follow the flow of the conversation, and had got some of the information mixed up as different participants shared their experiences. Will speak with supervisor regarding potential for individual contact rather than group. I think that while this group does not appear to be as resistant as the previous group, this one individual could struggle a lot and possibly have an impact on the group, so my sense would be to make a decision about their participation at this point rather than continue and have both hers and others have a poor experience of PMP as a result. Feeling more confident in myself and my decisions now.

3rd Mar PMP

Can feel a shift in the group since last week, I feel that getting moved into the bigger room has really helped, this room also has a variety of different seating and has allowed everyone to find a more comfortable position. They were much more talkative with each other as they arrived than they were last week. We started with a follow up discussion on last weeks talk regarding mood, and they all had different experiences they wanted to explore a little further. As a result we spent the first 35mins discussing the interplay between mood and pain and developed the talk from the previous week. This was unplanned and not detailed in any of the slides but I feel it was a really useful session for these participants. The OT followed up with her talk on goal setting, and the group engaged well with this, with some linking their goals back to their mood. This was definitely needed for me after the last group before Christmas, these participants have started to make the links between the various talks quite easily, they have sparked further discussion on a talk they had last week and as a result are possibly going away with the potential to make a bigger impact on their own pain management skills – this is the part that I enjoy, excited again!

10th Mar The Role of Health Psychology in PMP (GP's)

A similar request, to that from the physiotherapy department has come in from a local GP practice requesting input from health psychology on the management of chronic pain. The talk that I had already developed and delivered to the physios was condensed to meet the time limits of the GPs (20 mins). I also asked the physiotherapist for the PMP to join me in delivering the talk as I felt her experience would be beneficial. It sparked conversation again, about appropriateness of referrals and I feel has opened the lines of communication going forward. This was a really useful talk to be involved in, it has often felt like the GP's possibly don't value the role of PMP, however following this it is possibly more a case of them not being clear about the role of the various groups within both the hospital and the community. This is something that I am keen to follow up on with this practice but also with the other practices locally too.

11th June The Role of Health Psychology in PMP (Physio Alt-Virtual)

Following on from the talk delivered to colleagues in the Southern sector of the Trust, their colleagues in the Northern sector (8) requested the same training/talk. Due to COVID 19 restrictions this was delivered via zoom. Connection issues meant that it began late (felt unprofessional) and as a result of a large demand for multi-media rooms I was unable to continue the talk beyond the time scheduled, therefore the 45min talk was condensed to 30min. This wasn't as bad as it could have been due to the fact that I had already delivered a 20 minute version of this to GP's earlier in the year. However, this group could have benefitted from further time. I followed with 2 of the lead physios in this department up a few days later to answer queries arising from the presentation. Thankfully the fact that the other physio department had already benefited from this talk and there was good communication between the departments, meant that a lot of their queries had already been address by their colleagues. I really feel that this has been such a useful experience for everyone involved, I have a greater understanding of the challenges facing the physios and they are now clearer on what the role of health psychology is the management of chronic pain at least – this is not always something that I feel is easy to communicate with other health professionals, so I'm really encouraged by this. I think there is also an element of me being more confident in my role and therefore more able to express that role clearly as I progress in my training.

3rd Sept Psychoneuroimmunology 1

Part one of a series of 5 (will form the basis of my teaching series), delivered to 7 psychology colleagues. This was a 20 min lunch time session delivered virtually via zoom. Zoom is an additional issue to consider alongside the information being presented. Knowing that I needed to deliver a teaching series as part of my teaching competency, I was keen to deliver something around psychoneuroimmunology within the health psychology department. Having had a conversation with one of the qualified clinical psychologists on the other hospital site at Christmas time about how our role in psychology had an impact physically on patients and how she was unable to detail this with a consultant, I felt very strongly that there was a need to revisit this topic. I discussed this with my line -manager and she was happy to support me in developing my teaching series around this. I revisited the training I had received at both MSc and Prof. Doc level and considered how this applied to the population we as a team were working with and started to develop my teaching series for there. I was conscious that I had a tight time limit to deliver something that was relevant and that would generate interest, so made sure to utilise a number of mediums involving the trusty PowerPoint slides, short videos and discussion points along the way. I also had the awareness that all staff from PWP right through to Consultant Clinical Psychologist, had all covered this topic at least at undergraduate level and so was working from that baseline. As a result, I was concerned that the introductory session might have been pitched too low – however this didn't appear to be the case and I was shocked at some of the questions posed. I'm glad to have this 1st one complete, although its still a very strange feeling as a junior member of staff to be offering a teaching session to fully qualified, more experienced staff. It felt awkward to begin with and I'm aware of speaking too quickly initially, however I think the questions that arose started to help me feel more at ease as it was obvious that the staff posing them had forgotten any psychoneuroimmunology they had previously been taught.

10th Sept Psychoneuroimmunology 2

2nd of the series, only 5 attendees today. I started the session by checking if there were any queries or comments on the previous weeks training. It appears that it had sparked renewed interest in exploring the basics of stress with patients, and 2 of the qualified

staff had queries about how psychoneuroimmunology might impact specific conditions. This was encouraging and as we moved through the planned content for this session, some of their queries were addressed to come degree. I'm really pleased with this session and the feedback, it feels like I pitched the level just right as one of the Band 5 PWP's also had very positive feedback. Although, the other side of that is, maybe I should be more concerned, I had expected experienced staff working in condition specific fields to be more aware of the impact of psychoneuroimmunology in their area!! But then I knew there was at least one member of qualified staff who wasn't, so I shouldn't really be surprised that there are others who had neglected to consider this aspect either, although working in a health psychology department, surely it's a must!!

17th Sept Psychoneuroimmunology 3

Flop!! Using the multi-media room in the hospital as it has great facilities particularly when hosting a group. So I had Zoom up and running, everyone logged in on time and good to go but unable to hear me. I adjusted everything possible, restarted the meeting, started a new meeting, and nothing worked – so frustrated. After 10 minutes I decided that it would be best to reschedule. Communicated with the team via the chat function and arranged to do a double session the following week! Stress ++

18th Sept Virtual PMP

1st virtual PMP. Three staff in attendance to start, 2 Psych, 1 physio. I opened up the session, introduced everyone and ran through the general housekeeping instructions etc. There were a number of hiccups to begin with, with some connection issues for some of the patients, no video/no sound etc. Thankfully there were no issues on our side following last week fiasco with =my training. I remained calm, talked a few of the participants through their connection issues and we were good to go. The majority of the talk was carried out by my colleague but I was still exhausted yet exhilarated once we had it finished - #newwaysofworking!! I never imagined we would deliver PMP via Zoom but it has many potential benefits for both patients and staff, very exciting.

24th Sept Psychoneuroimmunology 3&4

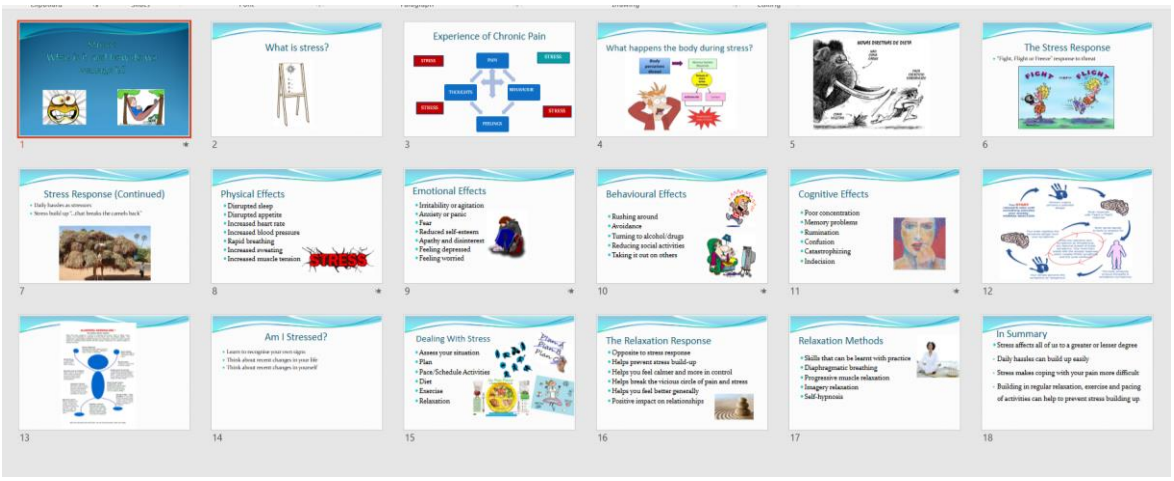
Working from home today – connection all to myself (the kids and my husband!), own laptop – no shared equipment – yeah!! I had 2 sessions to covering as a result of technical issues last week, so I had negotiated a longer overall session with my line manager and weaved together both talks a little more so they flowed more seamlessly. It appeared to work ok and Mary (line manager) stated at the end that she felt the talk had a good overall structure and tied theoretical and interventional pieces together nicely. Delighted with that verbal feedback. I think the technical issues last week, while stressful at the time, were possibly no bad thing. I panic at times that something like that will happen, and in this case it did, but it was well managed and having delivered both sessions today possibly worked better than delivering them individually. I am also starting to notice how uncomfortable I am presenting sitting down though – I think I need to reposition myself so I can deliver these talks standing sometimes – although I'll probably be moving around too much then. I hadn't really thought about that at the outset having really only used Zoom to participate in meetings where its normal to be sitting, I tend to move around the front of the room more when I'm delivering a piece of work normally. I'm definitely feeling much more confident as I reach the end of this teaching series and I think the fact that everyone is so engaged has really helped.

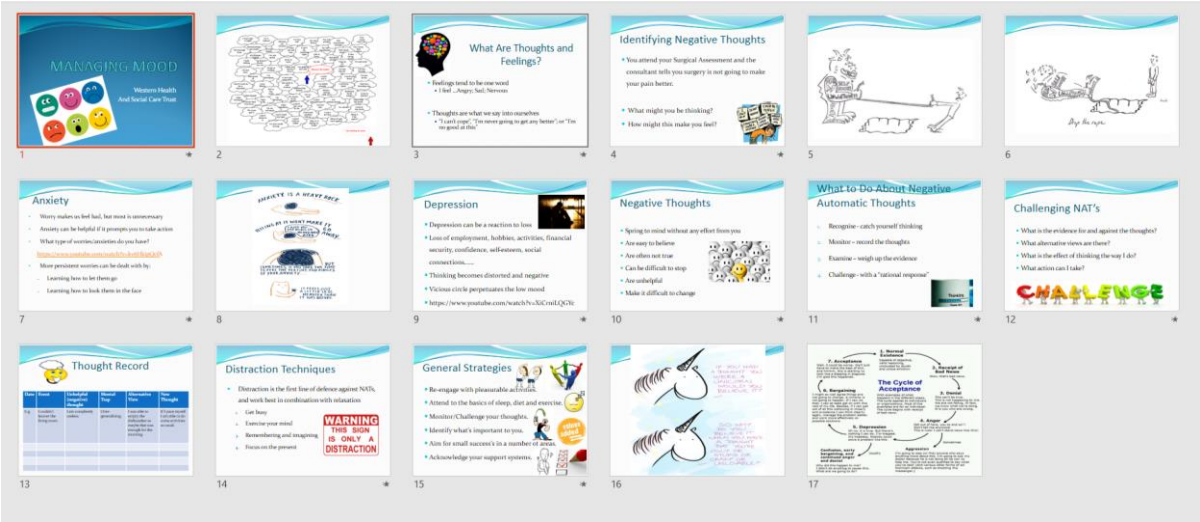
1st Oct Psychoneuroimmunology 5

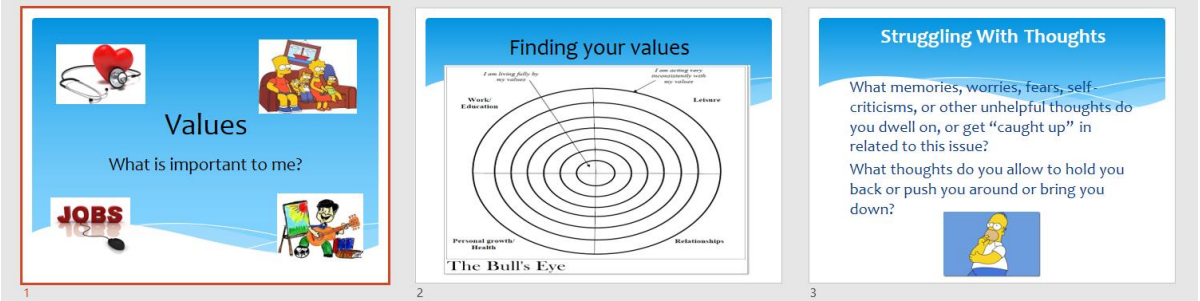
So today was the last session of my teaching series, I was using the shared equipment again and was a little nervous, but thankfully no hiccups today. We did a short recap session followed by more in-depth case discussion between the participants and the benefits of refreshing the thinking in this area. I am unsure if it was only a refresher for some of the team, the more we progressed the more I believe that 2 team members in particular had either studied quite some time ago or had never really fully comprehended the importance of this topic in healthcare populations. I would be keen to develop a rolling teaching series where each member of the team could deliver on an ongoing basis. The team has a wealth of knowledge and this would be a useful way of sharing that knowledge within the team without impacting on the business element of team meetings. While this teaching series was initially nerve provoking, it was a useful experience in terms of building confidence. Not only that I think it has genuinely sparked

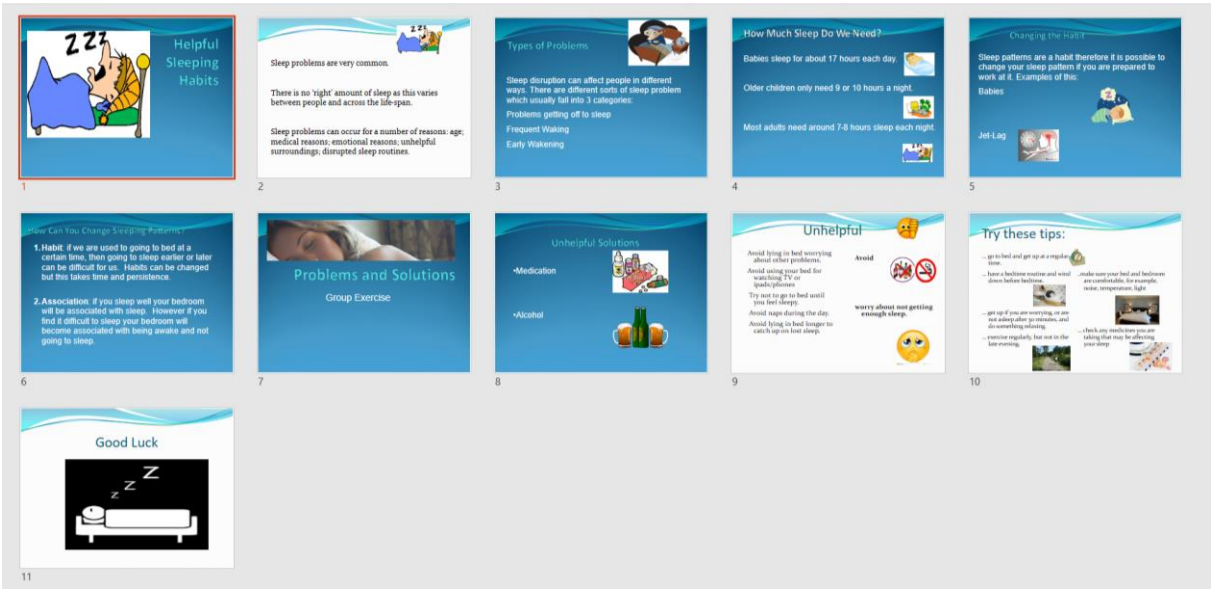
a renewed interest with some of the team to consider how their work impacts our patients not only on an emotional level but on a physical level too.

Appendix 1: PMP Structure & Psychology Talks




MANAGING MOOD
Western Health And Social Care Trust
What Are Thoughts and Feelings?
Identifying Negative Thoughts
Anxiety
Depression
Negative Thoughts
What to Do About Negative Automatic Thoughts
Challenging NAT's
CHALLENGE
Thought Record
Distraction Techniques
WARNING THIS SIGN IS ONLY A DISTRACTION
General Strategies
The Cycle of Acceptance


Values
What is important to me?
JOBS
Finding your values
Work/ Education
Leisure
Personal growth/ Health
Relationships
The Bull's Eye
Struggling With Thoughts
What memories, worries, fears, self-criticisms, or other unhelpful thoughts do you dwell on, or get "caught up" in related to this issue?
What thoughts do you allow to hold you back or push you around or bring you down?
Avoiding Challenging Situations:
What situations, activities, people or places are you avoiding or staying away from?
What have you quit, withdrawn from, dropped out of?
What do you keep "putting off" until later?
YES
NO
MAYBE
DON'T KNOW
Struggle With Feelings
What emotions, feelings, urges, impulses, or sensations (associated with this issue) do you fight with, avoid, suppress, try to get rid of, or otherwise struggle with?
How are you feeling?
Life-draining Actions:
What are you currently doing that makes your life worse in the long term: keeps you stuck; wastes your time or money; drains your energy; restricts your life, impacts negatively on your health, work or relationships; maintains or worsens the problems you are dealing with?


Helpful Sleeping Habits
Sleep problems are very common.
There is no 'right' amount of sleep as this varies between people and across the life-span.
Sleep problems can occur for a number of reasons: age; medical reasons; emotional reasons; unhelpful surroundings; disrupted sleep routines.
Types of Problems
Sleep disruption can affect people in different ways. There are different sorts of sleep problem which usually fall into 3 categories:
Problems getting off to sleep
Frequent Waking
Early Wakening
How Much Sleep Do We Need?
Babies sleep for about 17 hours each day.
Older children only need 9 or 10 hours a night.
Most adults need around 7-8 hours sleep each night.
Changing the Habit
Sleep patterns are a habit therefore it is possible to change your sleep pattern if you are prepared to work at it. Examples of this:
Babies
Jet-Lag
How Can You Change Sleeping Patterns?
1. Habit: if we are used to going to bed at a certain time, then going to sleep earlier or later can be difficult for us. Habits can be changed but this takes time and persistence.
2. Association: if you sleep well your bedroom will be associated with sleep. However if you find it difficult to sleep your bedroom will become associated with being awake and not going to sleep.
Problems and Solutions
Group Exercise
Unhelpful Solutions
•Medication
•Alcohol
Unhelpful
Avoid
worry about not getting enough sleep.
Try these tips:
Good Luck
1
2
3
4
5
6
7
8
9
10
11


Western Health and Social Care Trust
Flare-ups & Setbacks
Flare-ups
You may be feeling more positive about managing your pain but can still experience a rapid increase in your pain
"Bad day = Flare-up"
What you do will make a difference to:
How often you have a flare-up
How long it lasts
How severe it is
Flare-ups
You will need to continue to remember to
Pace your activity
Manage your stress
Exercise and keep active
These things should help prevent flare-ups and make them more manageable.
Managing Flare- Ups
Stop what you are doing and have a short break
After this start to mobilise slowly, setting some
Simple goals e.g. walking, stretching exercises
Pace yourself by working only to those goals
Try to relax using whatever techniques work well for you
Distract yourself. Remember that tension just makes pain worse
Challenge any negative thoughts, but be realistic
Flare-ups
Take your prescribed medication. It is most useful in a flare-up of pain
You may find that medication that was previously ineffective is more powerful if you have not take any for a while
Take regular dose
Consult doctor if reducing or re-taking medication
Things to Avoid
Continuing with an activity without thinking
Catastrophising
Going to bed - is a long rest the answer?
Calling the doctor out or visiting surgery. You know by now that unless there is a new problem there is nothing the doctor can do except to prescribe medication
Setbacks
A setback is when your pain gets gradually worse over a period of time
It is unlikely to be caused by any new damage, but more likely due to uncontrollable and/or stressful events
Activities, exercises and pacing often reduce
Therefore it is important to recognise when you are having a setback and to have a plan to deal with it
"Rules of Thumb"
"DON'T PANIC!!". This is only temporary. Do not stop everything - this is not a flare-up.
Keep doing your exercises, but only do half your usual number for each one.
Cut all your sitting, standing and walking time limits by half.
Increase your relaxation time
"Rules of Thumb"
Make a plan of how you are going to gradually increase your exercises and activity
Set yourself realistic goals
Try to establish what may have caused this setback - for future reference
Conclusion
Pain management is a skill
The more you practice the better you will get
Take credit for your achievements
Seek encouragement from others
The more naturally and automatically you manage your pain, the more you will be able to relax and pace yourself
1
2
3
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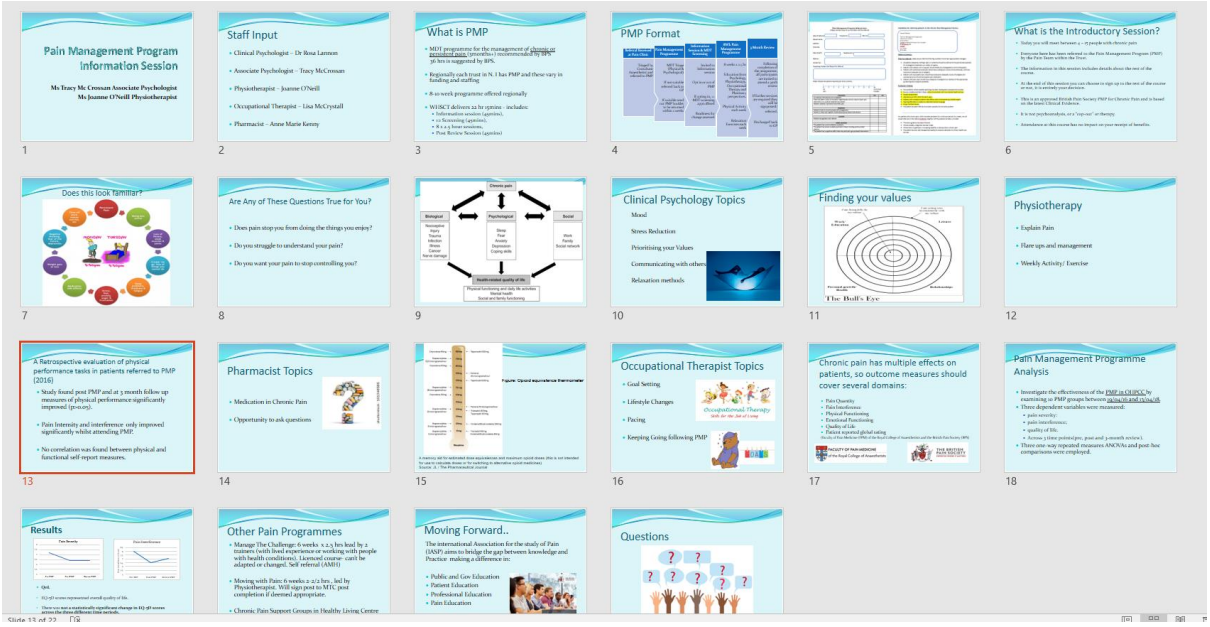
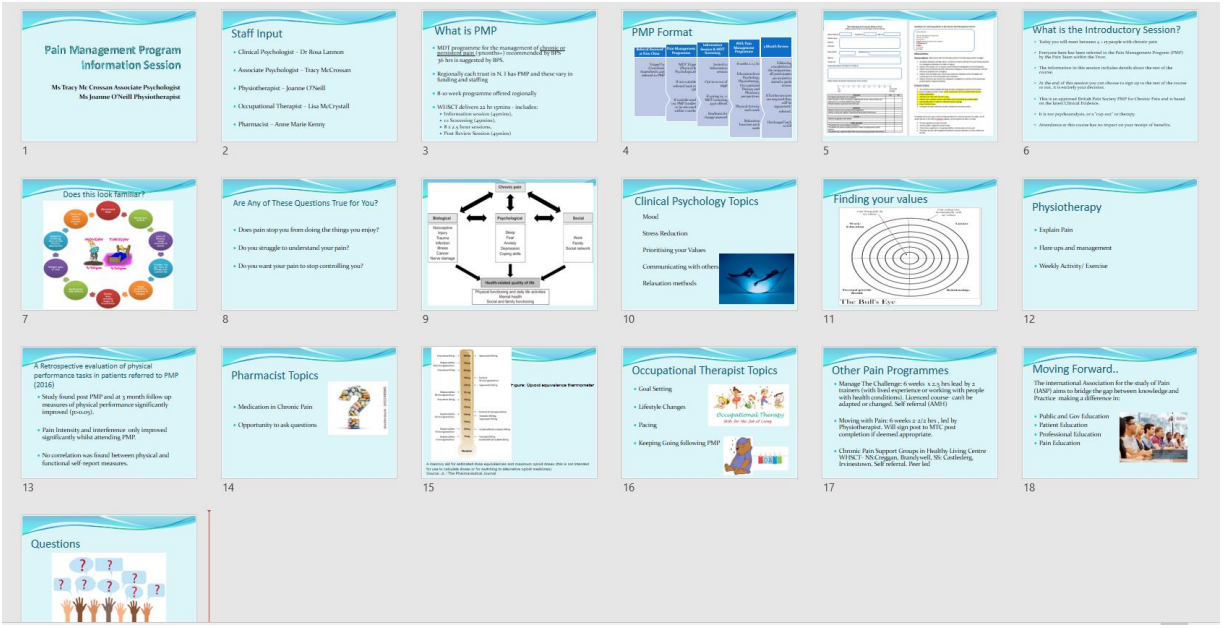
Appendix 2: The Role of Health Psychology in PMP for Physiotherapists

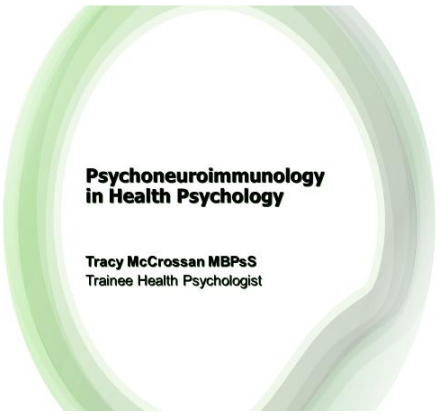


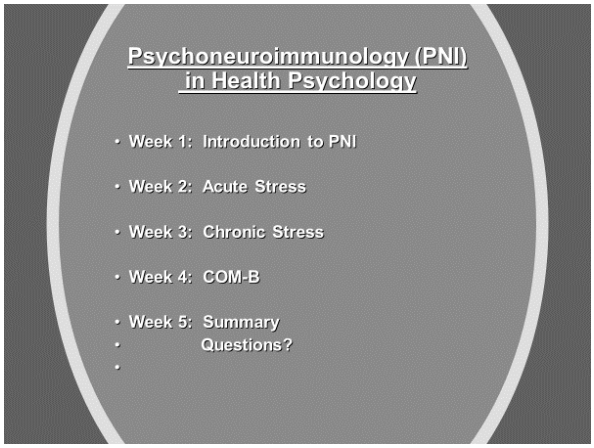
Appendix 3: The Role of Health Psychology for GP's

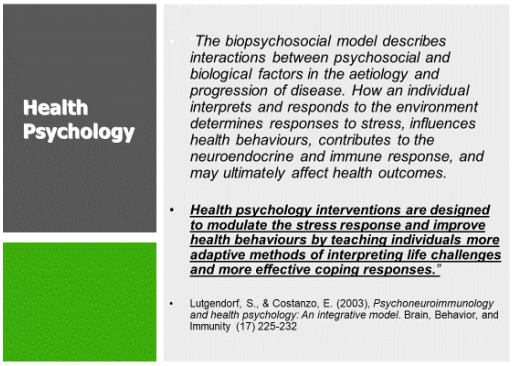


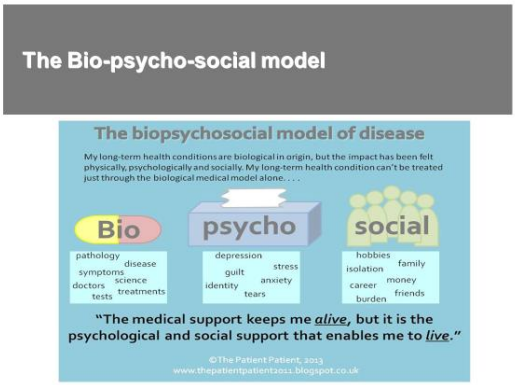
Appendix 4: Teaching Series Program Structure and Content

Week 1

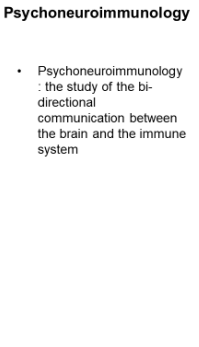


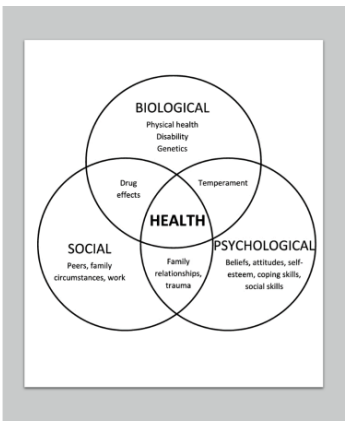


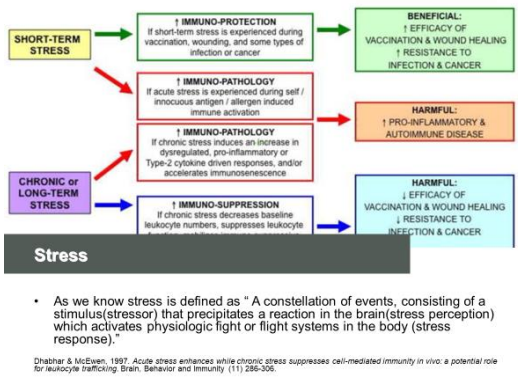


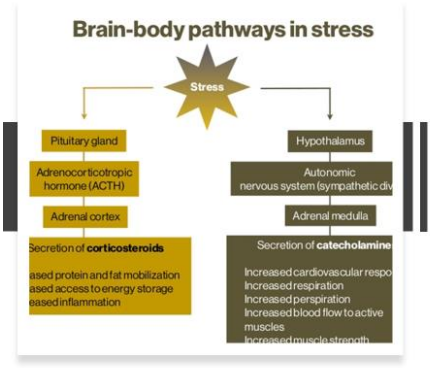


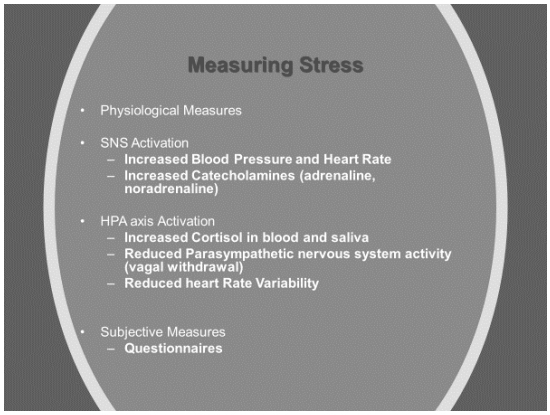
https://www.youtube.com/watch?v=sabuBhSIffI

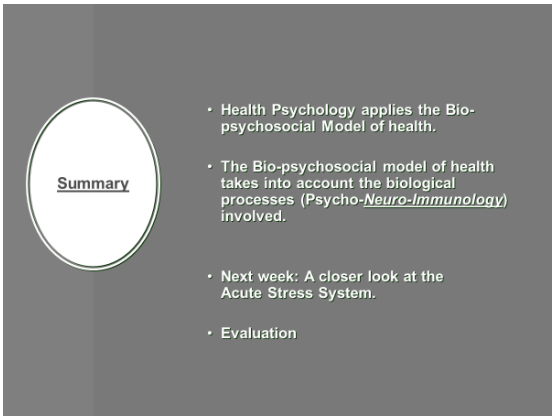




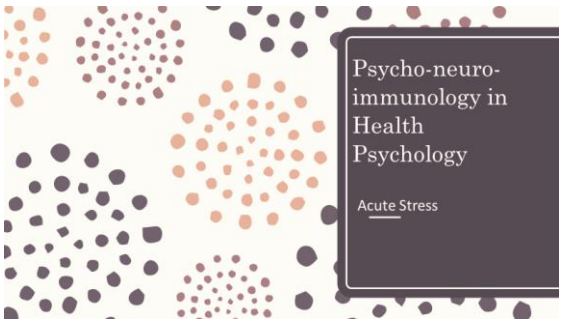


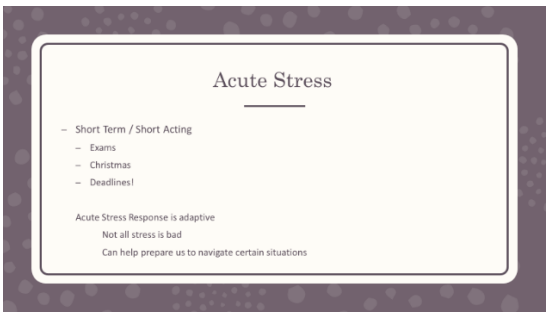


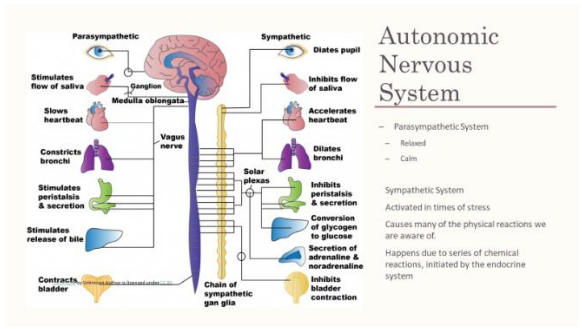

Measuring Stress
Physiological Measures
SNS Activation
Increased Blood Pressure and Heart Rate
Increased Catecholamines (adrenaline, noradrenaline)
HPA axis Activation
Increased Cortisol in blood and saliva
Reduced Parasympathetic nervous system activity (vagal withdrawal)
Reduced heart Rate Variability
Subjective Measures
Questionnaires

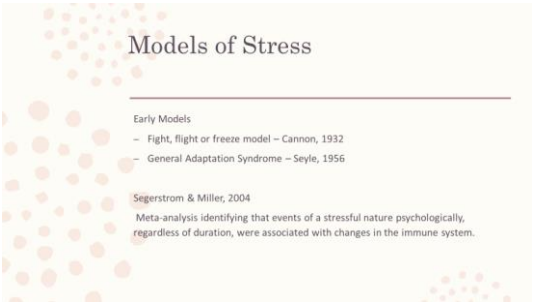

Summary
Health Psychology applies the Bio-psychosocial Model of health.
The Bio-psychosocial model of health takes into account the biological processes (Psycho-Neuro-Immunology) involved.
Next week: A closer look at the Acute Stress System.
Evaluation

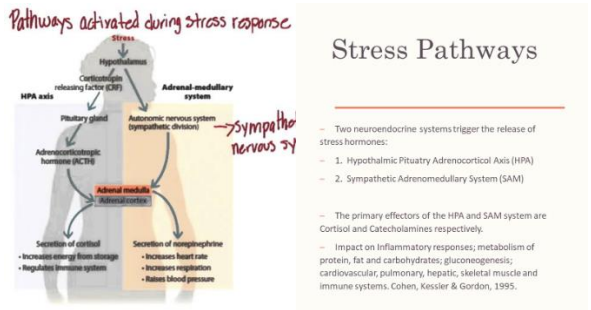
Week 2

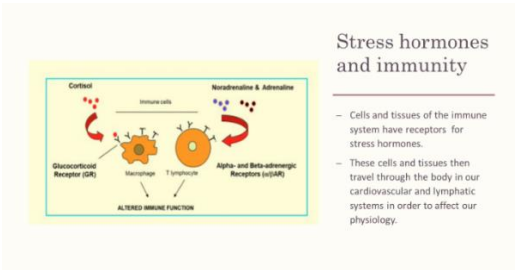

Psycho-neuro-immunology in Health Psychology
Acute Stress

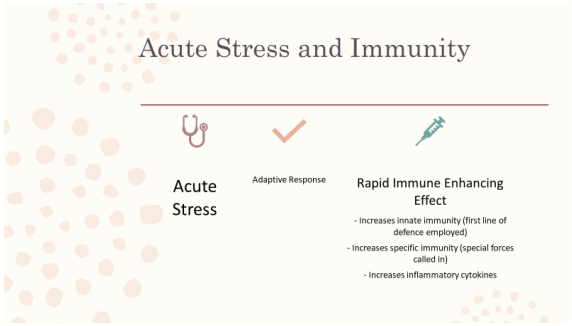

Acute Stress
Short Term / Short Acting
Exams
Christmas
Deadlines!
Acute Stress Response is adaptive
Not all stress is bad
Can help prepare us to navigate certain situations

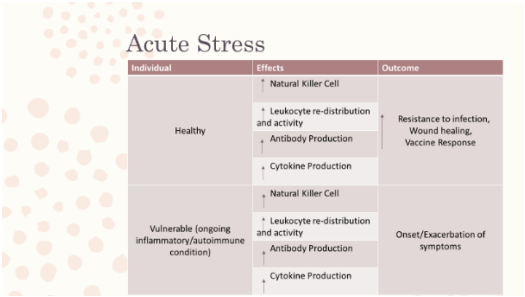

Parasympathetic
Sympathetic
Dilates pupil
Stimulates flow of saliva
Ganglion
Medulla oblongata
Inhibits flow of saliva
Slows heartbeat
Accelerates heartbeat
Vagus nerve
Constricts bronchi
Dilates bronchi
Solar plexus
Stimulates peristalsis & secretion
Inhibits peristalsis & secretion
Conversion of glycogen to glucose
Stimulates release of bile
Secretion of adrenaline & noradrenaline
Contracts bladder
Chain of sympathetic gan glia
Inhibits bladder contraction
Autonomic Nervous System
Parasympathetic System
Relaxed
Calm
Sympathetic System
Activated in times of stress
Causes many of the physical reactions we are aware of.
Happens due to series of chemical reactions, initiated by the endocrine system

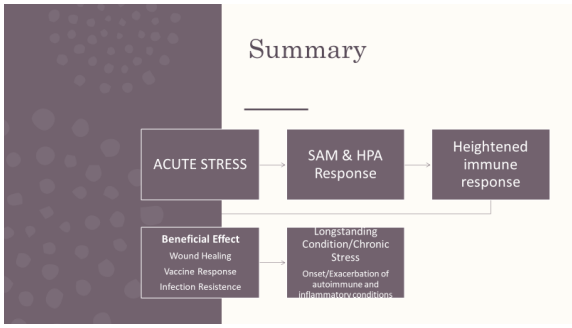

Models of Stress
Early Models
Fight, flight or freeze model – Cannon, 1932
General Adaptation Syndrome – Seyle, 1956
Segerstrom & Miller, 2004
Meta-analysis identifying that events of a stressful nature psychologically, regardless of duration, were associated with changes in the immune system.

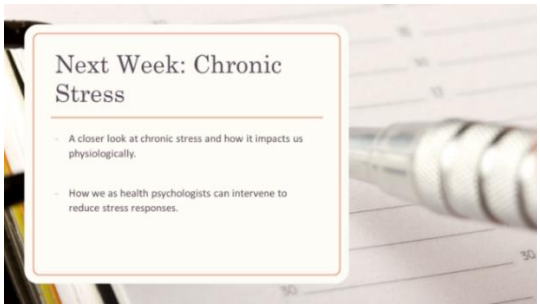

Pathways activated during stress response
Stress
Hypothalamus
Corticotropin releasing factor (CRF)
Adrenal-medullary system
HPA axis
Pituitary gland
Autonomic nervous system (sympathetic division)
Adrenocorticotropic hormone (ACTH)
Adrenal medulla
Adrenal cortex
Secretion of cortisol
Increases energy from storage
Regulates immune system
Secretion of norepinephrine
Increases heart rate
Increases respiration
Raises blood pressure
Stress Pathways
Two neuroendocrine systems trigger the release of stress hormones:
1. Hypothalmic Pituatry Adrenocortical Axis (HPA)
2. Sympathetic Adrenomedullary System (SAM)
The primary effectors of the HPA and SAM system are Cortisol and Catecholamines respectively.
Impact on Inflammatory responses; metabolism of protein, fat and carbohydrates; gluconeogenesis; cardiovascular, pulmonary, hepatic, skeletal muscle and immune systems. Cohen, Kessler & Gordon, 1995.


Cortisol
Noradrenaline & Adrenaline
Immune cells
Glucocorticoid Receptor (GR)
Macrophage
T lymphocyte
Alpha- and Beta-adrenergic Receptors (α/βAR)
ALTERED IMMUNE FUNCTION
Stress hormones and immunity
Cells and tissues of the immune system have receptors for stress hormones.
These cells and tissues then travel through the body in our cardiovascular and lymphatic systems in order to affect our physiology.

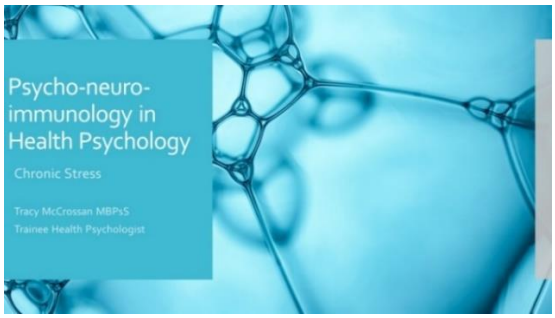

Acute Stress and Immunity
Acute Stress
Adaptive Response
Rapid Immune Enhancing Effect
- Increases innate immunity (first line of defence employed)
- Increases specific immunity (special forces called in)
- Increases inflammatory cytokines


Acute Stress
Individual
Effects
Outcome
Healthy
Natural Killer Cell
Leukocyte re-distribution and activity
Antibody Production
Cytokine Production
Resistance to infection, Wound healing, Vaccine Response
Vulnerable (ongoing inflammatory/autoimmune condition)
Natural Killer Cell
Leukocyte re-distribution and activity
Antibody Production
Cytokine Production
Onset/Exacerbation of symptoms

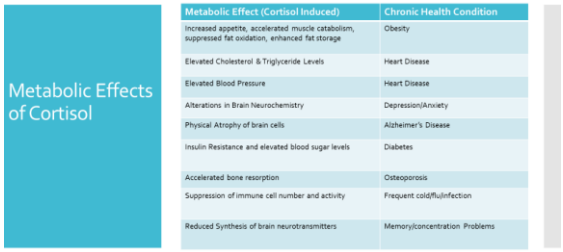

Summary
ACUTE STRESS
SAM & HPA Response
Heightened immune response
Beneficial Effect
Wound Healing
Vaccine Response
Infection Resistence
Longstanding Condition/Chronic Stress
Onset/Exacerbation of autoimmune and

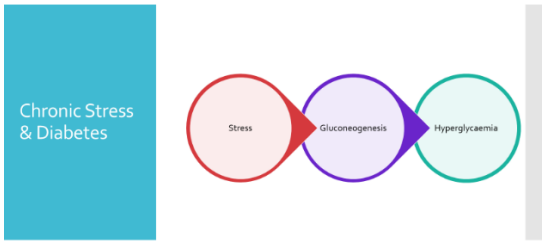

Next Week: Chronic Stress
A closer look at chronic stress and how it impacts us physiologically.
How we as health psychologists can intervene to reduce stress responses.

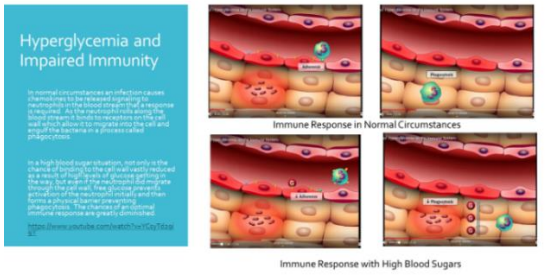
Week 3

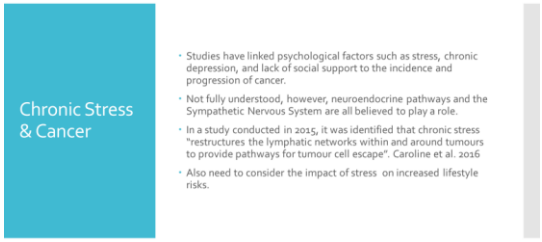

Psycho-neuro-immunology in Health Psychology
Chronic Stress
Tracy McCrossan MBPsS
Trainee Health Psychologist


Acute vs Chronic Stress
ACUTE STRESS
ADAPTIVE RESPONSE
RAPID IMMUNE ENHANCING EFFECT
CHRONIC STRESS
MALADAPTIVE RESPONSE
IMMUNE SUPPRESSING EFFECT


Metabolic Effects of Cortisol
Metabolic Effect (Cortisol Induced)
Chronic Health Condition
Increased appetite, accelerated muscle catabolism, suppressed fat oxidation, enhanced fat storage
Obesity
Elevated Cholesterol & Triglyceride Levels
Heart Disease
Elevated Blood Pressure
Heart Disease
Alterations in Brain Neurochemistry
Depression/Anxiety
Physical Atrophy of brain cells
Alzheimer's Disease
Insulin Resistance and elevated blood sugar levels
Diabetes
Accelerated bone resorption
Osteoporosis
Suppression of immune cell number and activity
Frequent cold/flu/infection
Reduced Synthesis of brain neurotransmitters
Memory/concentration Problems


Chronic Stress & Diabetes
Stress
Gluconeogenesis
Hyperglycaemia


Hyperglycemia and Impaired Immunity
Immune Response in Normal Circumstances
Immune Response with High Blood Sugars


Chronic Stress & Cancer
Studies have linked psychological factors such as stress, chronic depression, and lack of social support to the incidence and progression of cancer.
Not fully understood, however, neuroendocrine pathways and the Sympathetic Nervous System are all believed to play a role.
In a study conducted in 2015, it was identified that chronic stress "restructures the lymphatic networks within and around tumours to provide pathways for tumour cell escape". Caroline et al. 2016
Also need to consider the impact of stress on increased lifestyle risks.

Chronic Stress and Long-Term Conditions

1. Heart Disease
2. Pain
3. Respiratory
4. Renal
5. Rheumatology
6. Haematology
7. Gastroenterology
8. Neurology

Chronic Stress & Health Behaviours

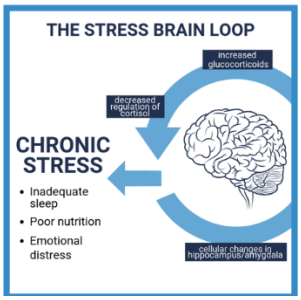
Chronic Stress

Chronic stress can be involved in the onset or exacerbation of chronic conditions.

Chronic Conditions in themselves are stressful.

Becomes a cyclical scenario.

Our role is to give the individuals that attend our service the tools they need to be able to manage/reduce their stress where possible.



Chronic Stress & Health Psychology

- Talking Therapies:
  - Part of the process of therapy is learning to express our emotions as feelings rather than physical symptoms.
  - Active engagement in therapy may indicate an acceptance of chronic illness and positive engagement in managing it, which in turn reduces perceived stress.
- Mindfulness:
  - Directed, focused attention, reduces cortisol, enhances neuroplasticity
- Hypnotherapy:
  - Cortisol levels have been shown to decrease during extended hypnotherapy. Scardino & Scardino 2014
- Thought Field Therapy:
  - Direct impact on Heart Rate Variability, which is regulated by cortisol levels.
- EMDR:
  - Regulated cortisol levels

Stress Management Techniques

- Yoga / Tai Chi / Meditation
- Regular sustained practice (year long adherence) required to achieve a reduction in circulating inflammatory markers Niklas et al. 2008.
- Tai Chi in particular shown to have a wide range of benefits such as improved balance, pain reduction, reduced stress, anxiety and depression, as well as enhanced immune function.
- In terms of reducing stress and coping with chronic illness it may be that stress management techniques which encourage more active coping, such as planning and support seeking are more likely to be associated with better psychological outcomes McCombie, Mulder & Gearry, 2013.

Next

COM-B: How it might inform talking therapies

Example of use in Assessment/Formulation in Diabetes

Week 4

Psycho-neuro-immunology

COM-B

COM-B

Behaviour Change

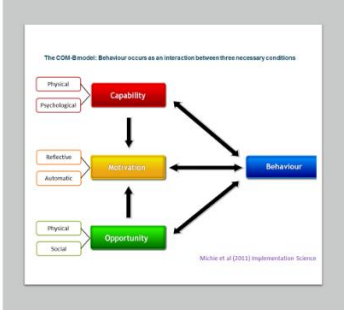
Limitations

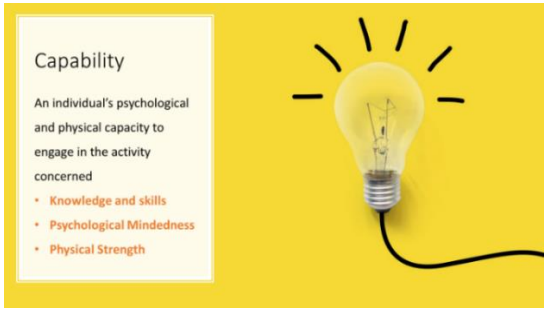
1. Limited explanation of health behaviour
2. Overlapping constructs
3. Context

(Michie et al, 2014)

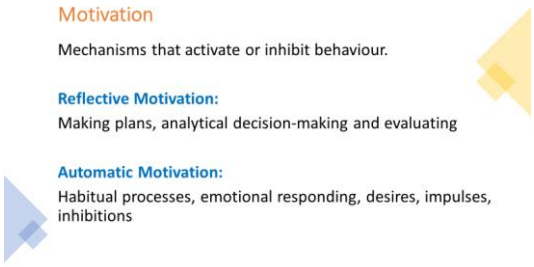
COM-B

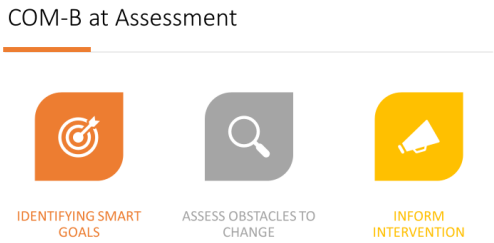
- Addresses lack of integration
- Simple starting point
- Interacting system




Capability
An individual's psychological and physical capacity to engage in the activity concerned
• Knowledge and skills
• Psychological Mindedness
• Physical Strength


Opportunity
Factors that lie outside the individual that make the behaviour possible
Physical:
• Time, location, resources
Social:
• Ecological Systems: SES, culture, access to healthcare

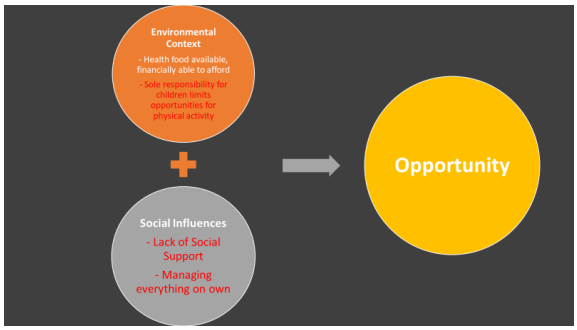

Motivation
Mechanisms that activate or inhibit behaviour.
Reflective Motivation:
Making plans, analytical decision-making and evaluating
Automatic Motivation:
Habitual processes, emotional responding, desires, impulses, inhibitions

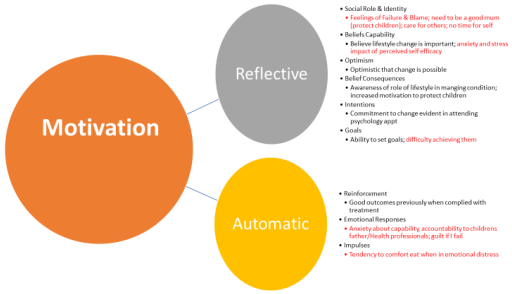

COM-B at Assessment
IDENTIFYING SMART GOALS
ASSESS OBSTACLES TO CHANGE
INFORM INTERVENTION


Case Example
Type 1 Diabetes Case

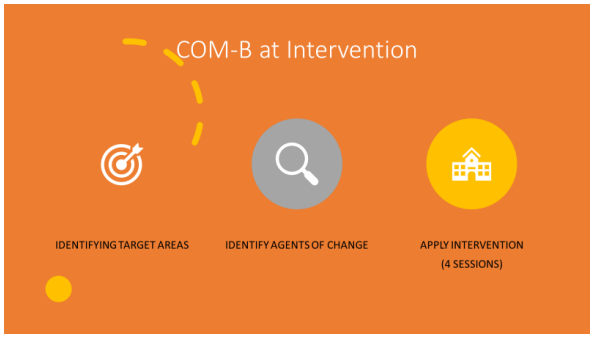

Capability
• Knowledge
• Skills
• Attention & Decision Making
• Behaviour Regulation
Opportunity
• Environmental Context
• Social Influences
Motivation
Diabetes Medication Adherence


Capability
Knowledge:
Generally good understanding of TIDM
Previous Good Control
Skills:
Posses the skills for BC
Posses Skills for Self Management
Attention & Decision Making:
Behaviour Regulation:
Avoiding assessment of diet and physical activity
Keeping BS high in the evening

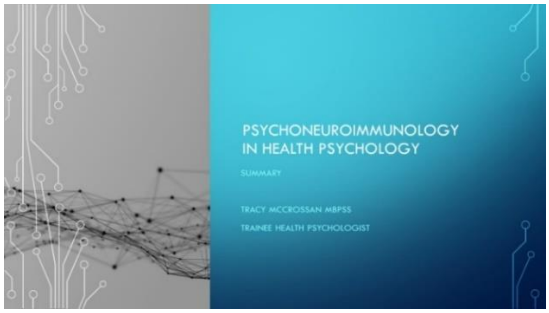

Environmental Context
- Health food available, financially able to afford
- Sole responsibility for children limits opportunities for physical activity
Social Influences
- Lack of Social Support
- Managing everything on own
Opportunity

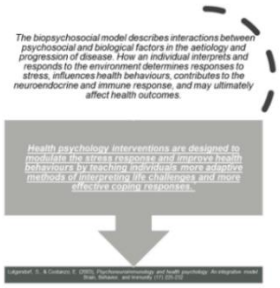

Motivation
Reflective
Automatic
• Social Role & Identity
• Feelings of Failure & Blams; need to be a good mum (protect children); care for others; no time for self
• Beliefs Capability
• Believe lifestyle change is important; anxiety and stress impact of perceived self efficacy
• Optimism
• Optimistic that change is possible
• Belief Consequences
• Awareness of role of lifestyle in managing condition; increased motivation to protect children
• Intentions
• Commitment to change evident in attending psychology appt
• Goals
• Ability to set goals; difficulty achieving them
• Reinforcement
• Good outcomes previously when complied with treatment
• Emotional Responses
• Anxiety about capability, accountability to childrens father/Health professionals; guilt if I fail
• Impulses
• Tendency to comfort eat when in emotional distress

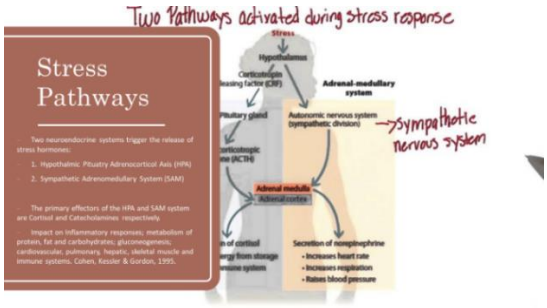

COM-B:
Assessment & Intervention
Assessment and formulation using the COM-B, highlighted specific areas to address which informed the intervention.
Capability
Opportunity
Motivation


COM-B at Intervention
IDENTIFYING TARGET AREAS
IDENTIFY AGENTS OF CHANGE
APPLY INTERVENTION
(4 SESSIONS)

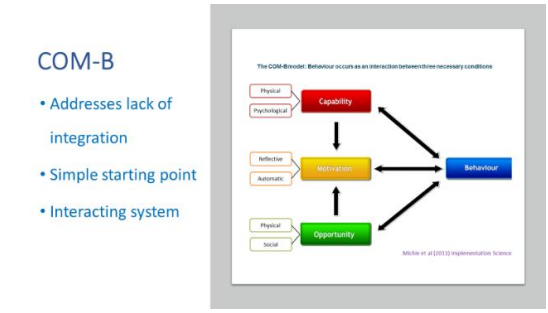
Week 5

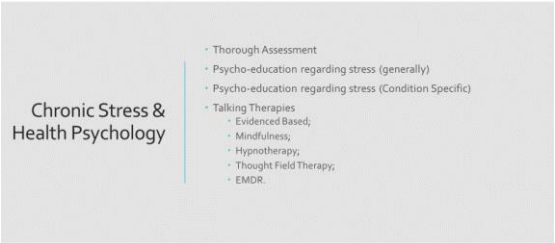

PSYCHONEUROIMMUNOLOGY
IN HEALTH PSYCHOLOGY
SUMMARY
TRACY MCCROSSAN MBPSS
TRAINEE HEALTH PSYCHOLOGIST

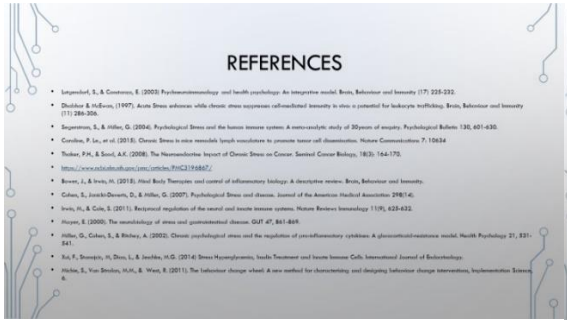

The biopsychosocial model describes interactions between psychosocial and biological factors in the aetiology and progression of disease. How an individual interprets and responds to the environment determines responses to stress, influences health behaviours, contributes to the neuroendocrine and immune response, and may ultimately affect health outcomes.
Health psychology interventions are designed to modulate the stress response and improve health behaviours by teaching individuals more adaptive methods of interpreting life challenges and more effective coping responses.


Two Pathways activated during stress response
Stress Pathways
Two neuroendocrine systems trigger the release of stress hormones:
1. Hypothalamic Pituitary Adrenocortical Axis (HPA)
2. Sympathetic Adrenomedullary System (SAM)
The primary effectors of the HPA and SAM system are Cortisol and Catecholamines respectively.
Impact on inflammatory responses; metabolism of protein, fat and carbohydrates; gluconeogenesis; cardiovascular, pulmonary, hepatic, skeletal muscle and immune systems. Cohen, Kessler & Gordon, 1995.
Stress
Hypothalamus
Adrenal-medullary system
Autonomic nervous system (sympathetic division)
sympathetic nervous system
Adrenal medulla
Adrenal cortex
Secretion of norepinephrine
- Increases heart rate
- Increases respiration
- Raises blood pressure


How Inflammation Affects the Body
Chronic Stress & Inflammation
– When we think of inflammation, we often think of the pain conditions, the rheumatoid arthritis, fibromyalgia etc.
– Inflammation affects many of our systems and as such its effects are much further reaching than we sometimes realise.
– In chronic stress the inflammatory system is highly active and has the potential to cause a number of different symptoms, therefore addressing stress from the outset can be key to addressing physical symptomology as well as reducing the emotional burden.


COM-B
• Addresses lack of integration
• Simple starting point
• Interacting system
The COM-Broodet: Behaviour occurs as an interaction between three necessary conditions
Physical
Psychological
Capability
Reflective
Automatic
Motivation
Behaviour
Physical
Social
Opportunity
Michie et al (2011) Implementation Science


Chronic Stress & Health Psychology
Thorough Assessment
Psycho-education regarding stress (generally)
Psycho-education regarding stress (Condition Specific)
Talking Therapies
Evidenced Based;
Mindfulness;
Hypnotherapy;
Thought Field Therapy;
EMDR.


REFERENCES


LINKS
• https://www.youtube.com/watch?v=sabuBhSIffI
• https://www.youtube.com/watch?v=YCsyTd29i9Y&t=43s

Appendix 5: Student Evaluation Forms from Teaching Series

Western Health and Social Care Trust

LIVERPOOL JOHN MOORES UNIVERSITY

Teaching Session 1 Feedback Form: Psychoneuroimmunology in Health Psychology

The session today refreshed my understanding of the topic?

Strongly disagree 1 2 3 4 (5) Strongly Agree

Was the content interesting?

Very Uninteresting 1 2 3 4 (5) Very Interesting

Did you find the session useful?

Not Useful 1 2 3 4 (5) Very Useful

The material was presented in a manner that facilitated understanding?

Strongly disagree 1 2 3 4 (5) Strongly Agree

What are the most memorable pieces of information you will take away from this session?

the viral role psychology plays in a person's medical recovery - "medical support keeps me alive ... psychological support that enables me to live" - poignant quote!

Would you like to add anything about the coverage or focus of the lecture?

NO - excellent Introduction.

Is there anything else you would like to say about the session?

the Layout x video were very ~~was~~ engaging x informative!

Western Health and Social Care Trust

LIVERPOOL JOHN MOORES UNIVERSITY

Teaching Session 2 Feedback Form: Psychoneuroimmunology in Health Psychology: Acute Stress

The session today refreshed my understanding of the topic?

Strongly disagree 1 2 3 4 (5) Strongly Agree

Was the content interesting?

Very Uninteresting 1 2 3 4 (5) Very Interesting

Did you find the session useful?

Not Useful 1 2 3 4 (5) Very Useful

The material was presented in a manner that facilitated understanding?

Strongly disagree 1 2 3 4 (5) Strongly Agree

What are the most memorable pieces of information you will take away from this session?

found it very interesting to think about how we as clinicians can impact our patients physiologically as well as psychologically, in terms of stress reduction.

Would you like to add anything about the coverage or focus of the lecture?

No - great session!

Is there anything else you would like to say about the session?

I always knought about the impacts of Chronic stress, but this session informed me about the impact of acute stress on our patients with long-term condition!

Appendix 6: Peer Review from Teaching Series

This teaching session was a valuable addition to ongoing CPD for staff. Whilst staff were familiar with most of the information there was a focus on returning to the basics of stress and its impact on physical health and illness. We as professionals often assume our clients have knowledge of the basics of stress and its role in physical and mental health and in reality our experience tells us this is simply not the case. As a result of these teaching sessions I have found myself focusing on this psycho education element of sessions for a little longer than previously which has had a noticeable impact on therapy.

Tracy's presentation style was relaxed yet organized in a methodical way with each session naturally linking on to the next. She opened the presentation up to the floor for questions and indeed was able to further add to subsequent sessions in order to address these.

Of note was Tracy's ability to adapt the teaching delivery using Zoom in light of Covid 19. She remained at ease throughout which aided delivery of content and created a comfortable dynamic which facilitated the audience's ability to understand the content.

Chapter 4: Research

Systematic Review

Psychological interventions: do they improve self-management in adults with Type II diabetes? A Systematic Review

Tracy McCrossan[1], Helen Poole[2], Mark Forshaw[2], Rosa Lannon[1], Mary Dooher[1].

Abstract

Diabetes mellitus, (T2DM) is a long-term condition (LTC) characterised by the body's ineffective use of insulin and can be caused by excess weight and physical inactivity. Lifestyle changes can be effective in both delaying the onset of type 2 diabetes, and in minimising its complications. Changes such as maintaining a healthy weight, staying physically active, eating a healthy diet and avoiding smoking can be challenging and many individuals require additional support to achieve and maintain them. Psychological interventions such as: Acceptance and Commitment Therapy, Cognitive-Behavioural Therapy, and Mindfulness-based Therapy, have become a key part of many multi-disciplinary specialist diabetes teams to offer such support. This review was conducted to evaluate the contribution that psychological interventions have made to the management of type 2 diabetes. Four electronic databases were searched for relevant studies. Seven out of 36 articles satisfied the inclusion criteria, with the overall methodological quality of trials being variable. Six of the seven articles indicated significant improvements in physiological or behavioural/psychosocial measures, some of which were sustained over time. It was concluded that psychological interventions can have a significant impact on self-management in adults with type 2 diabetes, when delivered by psychologically informed practitioners. There was a lack of heterogeneity in the degree of psychological training of healthcare professionals delivering the training and in how outcomes were measured. Therefore, future studies should include an exploration of standard measures of self-management in type 2 diabetes, which may facilitate a more full evaluation of the range of psychological interventions employed.

Introduction

It has been well documented that physical health outcomes are maximised by addressing the emotional and psychological needs of patients (Das, 2016). Neglecting

these needs can impact negatively on hospital stays, adherence to medical regimen, life expectancy and patient satisfaction with services (Martin, 2005).

Living with a life-threatening/life-limiting illness, being diagnosed with a long term condition, or experiencing an acute trauma such as stroke, or heart attack are understood to coincide with high levels of emotional distress (Johnston, 1998). Health psychologists are well placed to manage this distress, given their specialist training and their ability to implement evidence-based psychological interventions in a range of health care settings. The role encompasses much more than just direct clinical contact with patients, and involves working as part of multi-disciplinary teams, -consulting with other professionals to achieve the best clinical outcomes for the patient.

During MDT meetings, psychologists can work indirectly with patients using their skills and knowledge to advise and support staff in managing patients with complex mental and physical health needs (Christofides, Johnstone and Musa, 2012). The British Psychological Society's Division of Health Psychology (DHP) highlight the impact that teaching can have within a healthcare system. They suggest that training to support staff in facilitating patient behaviour change can indirectly enhance the development of 'practitioner-patient' relationships, which in turn can lead to greater adherence to medication/treatment regimens (Division of Health Psychology, 2013).

Access to psychological services may constitute an inherent difficulty for clients with diabetes. Physical health status may preclude attendance at scheduled appointments and therefore these clients may be unable to avail themselves of psychological assistance (Kalra, 2018). Alternatively, some clients with long-term physical health problems may be reluctant to acknowledge the presence of psychological issues which may impact upon their health and therefore refuse to engage with psychological services (Dejean et al., 2013).

Additionally, statistics show that the chances of developing depression are almost threefold in people living with diabetes, and those with diabetes and co-morbid depression frequently have associated difficulties in obtaining optimum glycaemic control, alongside higher rates of diabetic associated complications, and adherence to medication regimens (Fenton, 2006; Simon, 2007; Vamos, 2009). Diabetes has been

considered one of the most behaviourally and psychologically demanding illness (Cochran, 2008). Therefore, it has been suggested that a co-working approach between mental health and medical professionals may be favourable in terms of improving outcomes across both physical and mental health conditions (Fenton, 2006; Yohannes, 2010; Das, 2016).

The National Institute for Health and Care Excellence (NICE) acknowledge that identifying and treating psychological problems is essential in improve functioning in individuals whose quality of life has been compromised by their long-term condition (LTC) (NICE, 2009). Furthermore, NICE guidelines for diabetes management state that clinicians should "have appropriate skills in the detection and basic management of non-severe psychological disorders" (NICE, 2014, p.43).

Research evidence depicts a bidirectional relationship between depression and long-term physical health problems whereby long-term illness can cause and exacerbate depressive symptoms, whilst the presence of depression predisposes vulnerability to disease (NICE, 2009). Psychological aspects of LTCs such as diabetes are often overlooked however difficulties with psychosocial adjustments often arise following deterioration in physical health status (White, 2001).

This is reflected in the statistics; people living with diabetes are two to three times more likely to have depression, (Fenton, 2006; Simon, 2007; Vamos, 2009) and people with diabetes and co-morbid depression are associated with having poorer glycaemic control, more diabetic complications, lower medication adherence and higher mortality.

Approximately 90% of people with diabetes mellitus in the UK have type 2 diabetes (Diabetes UK, 2021a). If left untreated, high blood sugar levels can have serious complications, which is why focusing on optimum management of blood glucose levels is important. For some optimum blood glucose levels are dependent on regular medication, while for others they can be obtained through non-pharmacological interventions, such as diet management and regular physical activity. Despite these relatively inexpensive, simple interventions many individuals still struggle to adjust psychologically and to maintain stable blood sugar levels. The challenges associated with maintaining lifestyle change can cause considerable distress; this combined with the fact that anxiety and depression are common in individuals with diabetes (Gonzalez,

Tanenbaum and Commissariat, 2016) can have a negative impact on health behaviours and medical outcomes. Diabetes distress alone has been found to lower adherence to treatment regimens (Gonzalez-Burboa et al., 2019), while depression has been associated with impaired glucose control (Diabetes UK, 2016).

Self-management is described as "the cornerstone of diabetes care" (Yao et al., 2019), and consists of four basic skills; modifying diet; engaging in physical activity; taking regular medication; engaging in regular self-monitoring of blood glucose levels (International Diabetes Federation Guideline Development Group, 2014). Diabetes UK (2021b) refers to self-management as the times, outside of health professional consultations when one manages diabetes through the actions of deciding what and when to eat, how much exercise to participate in, how to control one's weight, and whether to take medication regularly. Therefore, self-management of a chronic condition is not just about ensuring medication adherence, but also deals with the impact of the condition on all aspects of daily life, encompassing the emotional and social aspects of daily life (Newman, 2009).

This study facilitates a systematic review of psychological interventions for type 2 diabetes that will explore the type and delivery mode of the interventions and their impact on self-management.

Methods

A systematic review of the literature was undertaken to identify the eligible studies exploring the effect of psychological interventions on Diabetes mellitus, Type 2 self-management. The Preferred Reporting Items for Systematic Reviews and Meta-Analysis (PRISMA) guidelines (Moher, 2009) was employed. Eligible studies from Jan 2015 – Jan 2021 were included.

Search Strategy

Four electronic databases (Medline, CINAHL, PsycInfo and Web of Science) were searched using relevant keywords and Boolean operators. The PICOS search terms were:

- Population – adults with diabetes mellitus, type 2.
- Intervention – Psychological Intervention.
- Comparison – No Psychological Intervention/Treatment as usual.

- Outcome – Improves self-management.
- Study design – Controlled studies.

The search criteria used the following keywords in isolation and in combination: psycholog* intervention*; Type II Diabetes; Type 2 Diabetes; T2D; Diabetes Mellitus; self-management.

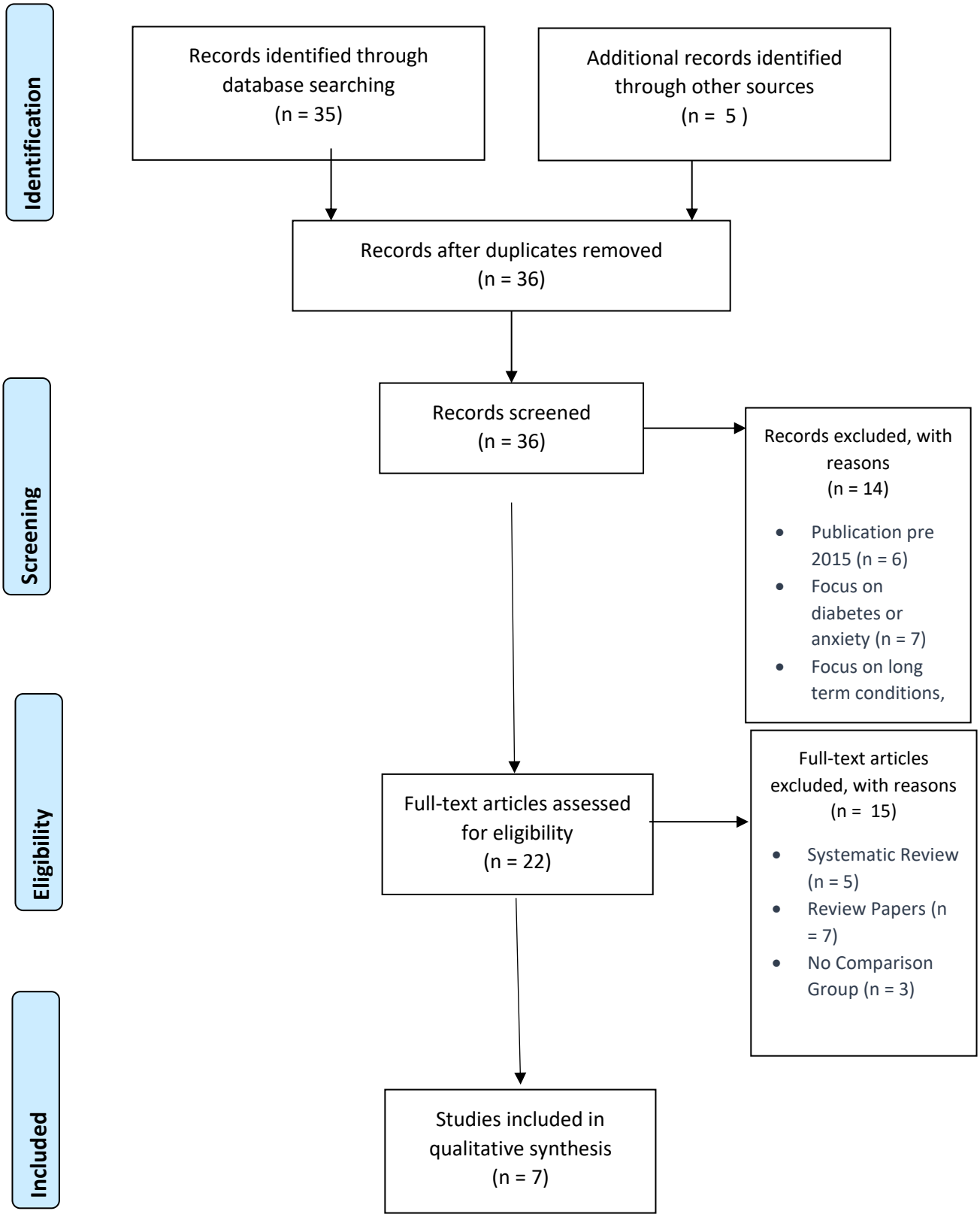
Study Selection

Records were selected based on study eligibility criteria, i.e. must be/have: 1. A controlled study; 2. Original research; 3. Contain at least one of keywords in title; 4. Publication between 2015-2021; 5. Publication in the English Language; 6. Full text.

Data Extraction

7 of 36 identified studies met the inclusion criteria (Shayeghian et al., 2016; Wagner et al., 2016; Ismail et al., 2018; Wroe et al., 2018a; Raveendranathan et al., 2019; Varming, 2019; Abraham et al., 2020). The relevant data, including study characteristics and study findings were extracted and recorded in Table 1. As inconsistencies across the studies were noted in terms of outcome measures and measurement procedures, findings are described narratively. A quality appraisal was carried out based on the GRADE (Higgins JPT, 2021) approach.

Figure 1. PRISMA (Preferred Reporting Items for Systematic reviews and Meta-Analyses) flow diagram for study inclusion.



Results

Figure 1 illustrates the process for article screening and selection using the PRISMA statement (Moher, 2009). Seven studies were eligible for inclusion (Shayeghian et al., 2016; Wagner et al., 2016; Ismail, 2018;; Raveendranathan et al., 2019; Varming, 2019; Abraham et al., 2020). The study characteristics are detailed in Table 1.

Participant and study characteristics

The studies selected included a total 903 participants, and were conducted across three continents: Europe n=571, USA n=211, and India n=121. Mean participant age ranged from 50 to 66 years and male and female genders were included in all studies. Study duration ranged from 1 year (n=106) to 3 years (n=97), and all studies entailed participant follow-up at one time point.

Intervention Characteristics

Psychological interventions were delivered in a range of settings as follows: 3 in hospital settings (Shayeghian et al., 2016; Raveendranathan et al., 2019; Abraham et al., 2020); and 1 in each of the following, a Specialist Diabetes Clinic (Varming, 2019); an IAPT setting ; Primary care (Ismail, 2018); and community setting (Wagner et al., 2016). The interventions were delivered in group (Shayeghian et al., 2016; Wroe et al., 2018b); and individual sessions (Wagner et al., 2016; Ismail, 2018; Raveendranathan et al., 2019; Varming, 2019; Abraham et al., 2020). In all studies the control group received usual care. Interventions included the following components: an exploration of challenges, values, goal setting, relaxation, problem solving and stress management (Wagner et al., 2016; Ismail et al., 2018; Wroe et al., 2018a; Raveendranathan et al., 2019; Varming, 2019; Abraham et al., 2020); with only one adopting a manual based ACT approach (Shayeghian et al., 2016). Interventions were delivered by a range of individuals, from specialist nurses (Ismail et al., 2018; Raveendranathan et al., 2019; Varming, 2019), researchers (Shayeghian et al., 2016), clinical psychologist (Abraham et al., 2020), Step 2 IAPT Psychological Wellbeing Practitioners (Wroe et al., 2018b) and community health workers (Wagner et al., 2016).

Outcome Measures

As highlighted earlier self-management of a chronic condition is a multi-faceted concept and as such, the range of measurements employed reflect this. Change in self-management is generally measured using a range of outcome measures, which include both medical and psychosocial/behavioural measures, however these

were not specifically designed to measure self-management. This systematic review identified four physiological outcome measures and 10 different psychosocial/behavioural scales used to assess self-management.

Glycated Haemoglobin (HbA1c) is what is produced when the body can't use sugar properly, the sugar (glucose) sticks to your red blood cells and builds up in the blood. Red blood cells are active for around 2-3 months, therefore HbA1c is an accurate measure of how well an individual has been managing their diabetes over time.

HbA1c was measured as the primary outcome in four studies (Wagner et al., 2016; Ismail et al., 2018; Varming, 2019; Abraham et al., 2020), and as a secondary outcome in two others (Shayeghian et al., 2016; Wroe et al., 2018b). Other physiological outcome measures investigated included Blood Pressure (BP) (Ismail et al., 2018; Varming, 2019), Body Mass Index (BMI) (Ismail et al., 2018; Varming, 2019), and cortisol levels (Wagner et al., 2016). In the remaining studies primary outcome measures were; Summary of Diabetes Self-Care Activities (SDSCA) (Shayeghian et al., 2016), Clinical Global Impression – Severity (CGS-I) (Raveendranathan et al., 2019) and a combination of the Patient Health Questionnaire 9 (PHQ-9) and the General Anxiety Disorder questionnaire 7 (GAD-7) (Wroe et al., 2018b).

Glycaemic and Physiological Outcomes

As highlighted, 4 studies reported HbA1c as the primary outcome, with 2 reporting HbA1c as a secondary outcome. In 3 studies, significant reductions in HbA1c were reported in the intervention compared to the control group (Shayeghian et al., 2016; Wroe et al., 2018b; Abraham et al., 2020). One study showed the reduction in HbA1c was sustained at three month follow-up (Shayeghian et al., 2016). The other studies showed either no significant change in HbA1c or other physiological outcomes such as body mass index (BMI) or blood pressure (BP) (Ismail et al., 2018; Varming, 2019), while one study found small decreases in cortisol levels of the intervention group (Wagner et al., 2016).

Behavioural and Psychosocial Outcomes

All studies included in this review incorporated behavioural or psychosocial outcomes as measures of psychological intervention effectiveness (Shayeghian et al., 2016; Wagner et al., 2016; Ismail, 2018; Wroe et al., 2018a; Raveendranathan et al., 2019; Varming, 2019; Abraham et al., 2020). Three of these studies included behavioural and

psychosocial measures as primary outcomes (Shayeghian et al., 2016; Wroe et al., 2018a; Raveendranathan et al., 2019).

The most commonly employed measure was the Summary of Diabetes Self Care Activities (SDSCA) (Toobert, 2000), with 3 of 7 studies utilising it (Shayeghian et al., 2016; Wroe et al., 2018b; Varming, 2019). The remaining 4 studies incorporated a range of self-report measures (Wagner et al., 2016; Ismail et al., 2018; Raveendranathan et al., 2019; Abraham et al., 2020). The most commonly reported measures were: self-care activities, such as physical activity, medication adherence, diet, testing sugars and checking feet (Shayeghian et al., 2016; Wagner et al., 2016; Wroe et al., 2018a; Raveendranathan et al., 2019; Varming, 2019; Abraham et al., 2020); symptoms of anxiety and depression (Wroe et al., 2018b); Quality of Life (QoL) (Abraham et al., 2020); Acceptance (Shayeghian et al., 2016); and Diabetes Distress (Wagner et al., 2016; Ismail, 2018).

Significant improvements in behavioural and psychosocial outcomes following psychological intervention were reported in 6 studies (Shayeghian et al., 2016; Wagner et al., 2016; Wroe et al., 2018b; Raveendranathan et al., 2019; Varming, 2019; Abraham et al., 2020), with significant differences between intervention and control groups in these studies. Two studies reported that the significant improvements obtained in the intervention group were sustained at follow-up (Wroe et al., 2018b; Raveendranathan et al., 2019). Two studies examined diabetes distress specifically, however, neither found significant improvements following intervention (Wagner et al., 2016; Ismail et al., 2018). One of these studies reported a reduction in diabetes distress over the course of the intervention, however this was not sustained (Ismail, 2018).

Three studies reported significant improvements in physical activity following intervention (Wroe et al., 2018a; Raveendranathan et al., 2019; Varming, 2019). Significant improvements in medication adherence were identified in the intervention group of three studies (Raveendranathan et al., 2019; Varming, 2019; Abraham et al., 2020). Both general diet and specific diet, as measured by the Summary of Diabetes Self-Care Activities scale, showed significant improvements in the intervention group in two studies (Wroe et al., 2018a; Abraham et al., 2020). Symptoms of anxiety and depression were measured using self-administered screening tools in one study only and

identified significant improvements in symptoms in both intervention and control groups, but with greater improvements in the intervention group (Wroe et al., 2018a).

One study reported significantly higher acceptance scores in the intervention group than the control group (Shayeghian et al., 2016). Quality of Life was specifically assessed using the Diabetes Quality of Life measure, results indicated significant improvements in quality of life in the intervention group only (Abraham et al., 2020).

Discussion

This article aimed to review the effectiveness of psychological interventions in improving diabetes self-management. Optimal glycaemic control is the result of adherence to self-management behaviours such as maintaining the treatment regimen; eating a healthy diet, keeping physically active and continued blood-glucose monitoring (Sridharan, 2016). As a result, studies exploring self-management of diabetes can tend to rely primarily on physiological outcomes such as Haemoglobin A1c (HbA1c), as was the case in four of the seven studies examined here (Wagner et al., 2016; Ismail, 2018; Varming, 2019; Abraham et al., 2020). Two of the remaining studies also examined changes in HbA1c in their secondary measures (Shayeghian et al., 2016; Wroe et al., 2018b). Interestingly, in the studies where changes in HbA1c was the primary outcome measure, only one study reported significant improvements (Abraham et al., 2020), while the two studies that included HbA1c as secondary measures identified significant improvements in the intervention group only (Shayeghian et al., 2016; Wroe et al., 2018b). Growing awareness of the importance of behavioural and psychosocial aspects of diabetes self-management is evidenced by the fact that all studies included in this review examined a varied range of behavioural/psychosocial measures. However, discrepancies exist with some of the studies indicating a lack of significant change in these areas at follow-up. The range of measures used to capture these outcomes suggest that there is a lack of consensus on the most suitable data collection tools. The studies examined here employed a range of general assessment tools and diabetes specific tools, and the lack of consistency in the results of this review may indicate the use of diabetes specific tools to assess changes in self-management. For example, three studies employed the Summary of Diabetes Self Care Activities (SDSCA) (Shayeghian et al., 2016; Wroe et al., 2018b; Varming, 2019). This scale looks at specific aspects of the diabetes regimen such

as general diet, specific diet, exercise, medication taking and blood glucose testing in a brief, non-judgemental measure (Toobert, 2000). These areas are specific to diabetes management therefore measuring these is likely to be more sensitive to the measurement of diabetes self-management, than more generic measurement tools such as the (Patient-Reported Outcomes Measurement Information System (PROMIS) or the Personal Health Questionnaire 9 (PHQ-9).

Similarly, the psychological interventions in these studies were delivered by a range of healthcare professionals; specialist nurses (3); researchers (1); clinical psychologist (1); IAPT workers (1); and community health workers (1). The range of healthcare professionals involved in the delivery of these interventions is encouraging given the public health strategy emphasizing the need for greater focus on preventative strategies (Department of Health, 2016; Public Health England, 2016). Health care professionals have the opportunity to facilitate behaviour change during their one-to-one contacts. This type of opportunistic behaviour change intervention has been the subject of investigation in recent years (Keyworth, 2020), and it is clear that healthcare professionals are a trusted source of health behaviour change advice (McPhail, 2012). In addition, patients often welcome health behaviour change advice during other healthcare consultations which are not necessarily focused on health behaviour (Aveyard et al., 2012). However, for this review the vast range of experience of those delivering psychological interventions adds to the heterogeneity of the studies and makes drawing conclusions difficult. If we look at the three studies (Ismail et al., 2018; Raveendranathan et al., 2019; Varming, 2019) that employed nurses as the healthcare professional delivering the intervention, firstly we can see that they all had some degree of specialist training. In two studies the specialist training was specifically diabetes related (Ismail et al., 2018; Varming, 2019), while in the third study the specialist training was in psychiatry initially with some additional training in diabetes (Raveendranathan et al., 2019). So, despite all having some additional training in diabetes, and encompassing similar intervention protocols, they are uniquely different and as a result, to infer that one intervention was more successful than another in this scenario would be inaccurate as we are not comparing like for like. In another three studies we are aware of the involvement of a healthcare professional with psychological training (Shayeghian et al., 2016; Wroe et al., 2018b; Abraham et al., 2020). Again, the range of experience within

these studies is varied, in one study a clinical psychologist working alongside the endocrinologist appears to offer support to researchers, however does not appear to be directly involved in the delivery of the intervention which involves delivering a 10-session group based ACT workshop (Shayeghian et al., 2016). Another study describes the intervention (routine care plus four additional sessions addressing education and relaxation, goal setting and values, problem solving, and managing mood), being delivered by the clinical psychologist (Abraham et al., 2020), and the in the final study the intervention, which is a wellbeing group with a clear focus on goal setting, behavioural activation, problem solving, cognitive restructuring, exposure therapy, and sleep hygiene, is delivered by psychological wellbeing practitioners, with additional training regarding thinking patterns and Type 2 Diabetes (Wroe et al., 2018a). Similarly, to draw direct comparisons between these studies, which all have overlapping elements, would be flawed. The remaining study involves delivery of an intervention by a community health worker (CHW) (Wagner et al., 2016), a CHW is an elected member of the community chosen to deliver basic care as a result of their understanding of the unique cultural contexts of health behaviour within that community. Again they have been given specific training in diabetes, but to contrast this study which involved delivering eight group sessions covering stress management, psychoeducational skills training and physical relaxation, with the others mentioned previously is problematic as the intervention is uniquely different from the others and the level of training of the CHW is not fully understood.

It is also important to note that the studies examined in this review employed both group and individual formats to deliver psychological interventions. While significant improvements were obtained in glycaemic and behavioural/psychosocial measures in studies including both group and one to one interventions, it is notable that these were delivered by psychologically informed staff. This may indicate that staff involved in delivering psychological interventions require a greater psychological knowledge base before embarking on delivering either individual or group interventions, as highlighted in Ismail et al. (2018). A growing body of evidence suggests that unhealthy behaviours are risk factors for long-term conditions such as diabetes (World Health Organisation, 2017). Internationally and regionally, public health strategies are emphasizing the need for greater focus on preventative strategies to address this (Department of Health, 2016;

Public Health England, 2016). As a result, the delivery of health behaviour change interventions by all healthcare professionals during their routine one-to-one contact with patients would offer maximum reach and efficiency. Unfortunately, the results of this review suggest that, at present, this target is not within reach. It is difficult however to pinpoint whether this is related to psychological skills of the health professional involved in delivery, the type of intervention, or indeed the lack of heterogeneity in the measurement of outcomes.

Conclusions

The daily demands of Type 2 diabetes mellitus are varied and complex and can cause significant diabetes-related distress (Hessler et al., 2015). These challenges combined with the fact that anxiety and depression are common in individuals with diabetes (Gonzalez, Tanenbaum and Commissariat, 2016) can negatively impact on health behaviours and subsequently physiological outcomes. This supports the need for appropriate psychological intervention to address distress, anxiety and depression, which was explored in 5 of the 7 studies included in this review (Wagner et al., 2016; Ismail et al., 2018; Wroe et al., 2018a; Varming, 2019; Abraham et al., 2020). However, again, the range of measures employed was variable with some measuring the emotional burden of diabetes (PAID-5), the emotional reactions to illness (IPQ-R), while others measured depression (PHQ-9), and anxiety more directly (GAD-7, PROMIS-SF8A). This study has explored a range of group and individual psychological interventions, delivered by both healthcare and community workers to identify if psychological intervention positively impacts on self-management of diabetes. In six of the seven studies examined, significant improvements were found in behavioural/psychosocial and physiological outcomes. However, there appears to be great variability in the range of measures used with a lack of diabetes specific measures employed, and this is an area that requires greater attention.

Future research should focus on understanding more about the psychological interventions that elicit changes in behavioural and psychosocial outcomes, in particular those that facilitate exploration of the *emotional* impact of type 2 diabetes. While the delivery of psychological interventions by a range of healthcare professionals is to be encouraged, greater focus should be given to the training and support of allied health

professionals to ensure the transfer of knowledge to effective implementation in practice.

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Appendix 1: Data Extraction Table

First author, year, location	Study type	Sample: No., mean age, sex, (diabetes duration)	Setting (duration); No./length of sessions	Intervention; Content	Format; Delivery Method	Main Outcomes Time of Measures	Main Results
Varming 2019 Denmark	Unblinded, parallel, RCT Data collected via completion of questionnaire: - Before randomisation - End of intervention - 6mth Follow-up	N = 97 IG: n=49 Mean age 63yrs Males – 61% CG: n= 48 Mean age 66yrs Males – 71% T2dm>1yr HbA1C> 64mmol	Specialist diabetes clinic Delivered by specialist diabetes nurses with special training in Empowerment, Motivation and Medical Adherence (EMMA) Oct '14 – Sept '17 5 sessions 6mth follow up	IG: • Usual care but with EMMA nurse, who focuses on: • Exploration of daily living and medication • Exploration of and work on challenges • Goal setting and planning • Mean no of cons – 18.9 CG: • Usual care: • Consultations with nurses, physicians, dieticians and chiropodists, telephone consultations and eye clinic appts.	One to one, face to face delivery & 1 x telephone delivery by EMMA nurse in IG One to one, face to face delivery by DSN in CG • IG: Mean no of cons – 18.9 • CG: Mean no of cons – 21.5	• *HbA1C* • Health Care Climate Questionnaire (HCCQ) • Treatment Self-Regulation Questionnaire (TSRQ) • Summary of Diabetes Self0Care Activities (SDSCA) • World Health organisation Wellbeing 5 (WHO-5) • Problem Areas in Diabetes (PAID-5) • Wellbeing, measured by changes in BMI and BP.	• At the end of intervention HCCQ and SDSCA healthy diet scores were significantly higher in the IG than CG, indicating that participants in the IG experienced more support without pressure from healthcare professional to maintain a health diet. This was sustained at follow up, but no longer significant from the CG. • No significant effect on HbA1C, BMI, BP, PCD, WHO-5, PAID and most of the SDSCA scores.

Appendix 1: Data Extraction Table

First author, year, location	Study type	Sample: No., mean age, sex, (diabetes duration)	Setting (duration); No./length of sessions	Intervention; Content	Format; Delivery Method	Main Outcomes Time of Measures	Main Results
				• Mean no of cons – 21.5			
Shayeghian 2016 USA	RCT Data Collection via questionnaire completion: - Prior to beginning (Brief COPE, SDSCA, AADQ). Blood Sample - Post treatment (SDSCA, AADQ). Blood Sample - 3mth Follow-up (SDSCA, AADQ). Blood Sample	N=106 IG; n = 53 10 sessions Mean age 55.18yrs female 66% CG; n = 53 10 sessions Mean age 55.7yrs, female 54% 3mth Follow-up; n=50	Hospital Participant data captured by researchers. Unclear who delivered ACT group although reference in protocol to clinical psychologist in team? Feb '13 – Jan'14 10 sessions 3mth follow up	IG: • Education (1 day education workshop) and • 10 sessions of group based ACT workshop CG: • usual care – 1 day education workshop	Face to face group workshop Based on ACT manual, unclear who delivered: researcher? Or clinical psychologist?	• *HbA1C* • Summary of Diabetes Self-Care Activities (SDSCA) • Acceptance and Action Diabetes Question (AADQ) • Brief COPE	• At the end of the intervention results showed that the IG exhibited significant effects on HbA1C, and that these results remained stable three months after completion. • It also indicated that those patients with an effective coping style significantly increased their self-care activities from baseline to end of treatment.
Raveendranathan 2019 India	Evaluation Data collection via questionnaire completion:	N = 41, Female n=25 (60.9%)	Tertiary Hospital Setting Intervention delivery by	IG: • Psychiatric nurses delivered: • routine clinical care and	IG: Psychiatric Nurse Face to Face One to one	• *CGI -S (Clinical global impression severity)*	CGI-S Clinical Global Impression Severity, patient VAS, brief physical activity questionnaire all showed sig improvement

Appendix 1: Data Extraction Table

First author, year, location	Study type	Sample: No., mean age, sex, (diabetes duration)	Setting (duration); No./length of sessions	Intervention; Content	Format; Delivery Method	Main Outcomes Time of Measures	Main Results
	- Prior to intervention using DDS to detect Diabetes related distress. Baseline measures. - Clinician rated Clinical Global Impression-Severity (CGI-S) rated by psychiatric nurse. - Patient rated visual analog scale (VAS) 1-10, reporting symptom severity. - Brief physical activity questionnaire and adherence to medication	Mean age 44.63yrs	psychiatric nurses with additional training in type 2 diabetes. 1 session 2mth follow up	• 1 single session (45-60 mins) intervention consisting of brief diabetes education focusing on: - physical activity and medication adherence, - relaxation techniques, -illness specific problem-solving strategies. CG: • Diabetes educator delivered routine clinical care which included diabetes education and dietary advice.	Single Session Usual Care Diabetes Educator Face to Face One to one Single Session	• Patient VAS. • Brief Physical Activity questionnaire. • Medication Adherence	from baseline to follow up in self-management practices such as physical activity and medication adherence.

Appendix 1: Data Extraction Table

First author, year, location	Study type	Sample: No., mean age, sex, (diabetes duration)	Setting (duration); No./length of sessions	Intervention; Content	Format; Delivery Method	Main Outcomes Time of Measures	Main Results
	assessed by Psychiatric nurse. 2mth follow-up measures. Clinician rated Clinical Global Impression-Severity (CGI-S) rated by psychiatric nurse. - Patient rated visual analog scale (VAS) 1-10, reporting symptom severity. - Brief physical activity questionnaire and adherence to medication assessed by Psychiatric nurse.						
Abraham 2020 India	RCT	N=80	General Hospital	Clinical Psychologist delivered	Face to face delivery by	• *HbA1c* • DQOL	IG: - significant improvement in HbA1c from baseline to

Appendix 1: Data Extraction Table

First author, year, location	Study type	Sample: No., mean age, sex, (diabetes duration)	Setting (duration); No./length of sessions	Intervention; Content	Format; Delivery Method	Main Outcomes Time of Measures	Main Results
	Measures collected at: Baseline, Post Intervention & 3mth follow-up: - HbA1C - Diabetes Quality of Life Measure (DQOL) - Summary of Diabetes Self - Care Activities (SDSCA) - Barriers to Self Care (BSC) - Illness Perception Questionnaire Revised (IPQ-R)	Type 2 diabetes > 1yr IG: n=40 Mean age 50.4, 18 male and 22 female CG: n=40, Mean age 50.6, 17 male and 23 female	Intervention delivered by clinical psychologist. 4 sessions IG: Self-Management Intervention CG: Treatment as usual 3mth follow up	IG: Treatment as usual + 4 sessions x 30-45mins on: 1.Education, Relaxation, 2. Goal setting, values, 3. problem solving, 4. managing mood CG: Treatment as usual including routine advice on diet, exercise, monitoring blood glucose levels and medication.	clinical psychologist. One to one	• SDSCA • BSC • IPQ-R	post intervention. Significant improvements in DQOL were observed at post intervention and follow up. - Significant improvement in SDSCA on domains of adherence, diabetes self-care including glucose testing, gen diet, specific diet and exercise at post intervention and follow-up.
Wroe 2017 UK	Controlled Trial Measures Collected at:	N=140 IG: n=63	Mar 12 – June 13 IAPT setting	Step 2 IAPT Workers (PWP) IG: Wellbeing group with a focus on goal	Face to Face, group delivery.	• *PHQ-9* • *GAD-7* • Management of T2 Diabetes	Significant improvements in Depression and Anxiety scores were observed from pre-post intervention in both IG and CG.

Appendix 1: Data Extraction Table

First author, year, location	Study type	Sample: No., mean age, sex, (diabetes duration)	Setting (duration); No./length of sessions	Intervention; Content	Format; Delivery Method	Main Outcomes Time of Measures	Main Results
	- Every Session: - PHQ-9 - GAD-7 - WSAS - 1st Session - Disinhibited Eating, and Summary of Diabetes Self-Care Activities (SDSCA) - Last Session - Disinhibited Eating, and Summary of Diabetes Self-Care Activities (SDSCA) - 3mth Follow-up - PHQ-9 - GAD-7 - SDSCA - WSAS	Mean age 63.48yrs 28 male, 35 female CG: n=52 Mean age 63.63yrs 27 male, 27 female	Step 2 IAPT workers (Psychological Wellbeing Practitioners) IG: Modified Wellbeing group. 6 sessions over 6 weeks x 1.5hrs per session. CG: Standard Wellbeing group. 6 sessions over 6 weeks x 1.5hrs per session. Follow up	setting, behavioural activation, problem solving, cognitive restructuring exposure therapy and sleep hygiene. Run by Step 2 IAPT workers with additional training from a health psychologist and GP. CG: Wellbeing group run by Step 2 IAPT workers.		using the 'Disinhibited Eating and Summary of Diabetes Self-Care Activities' questionnaire. • HbA1C • Measure of Work and Social Adjustment.	Measure of work and social adjustment, both IG and CG demonstrated no significant improvement in scores. On the (SDSCA) significant improvements were found in: 1. general diet and specific diet in IG. 2. Exercise demonstrated significant improvement in both IG and CG. 3. Testing sugar levels, a significant improvement in the IG. 4. Taking medication – no significant improvement in either group. 5. Frequency of checking feet – a significant

Appendix 1: Data Extraction Table

First author, year, location	Study type	Sample: No., mean age, sex, (diabetes duration)	Setting (duration); No./length of sessions	Intervention; Content	Format; Delivery Method	Main Outcomes Time of Measures	Main Results
	- 3-9mths post intervention - HbA1C						improvement in IG. 6. In glycaemic control a significant improvement in IG only. At follow up CG showed significant improvements in anxiety and depression, while IG showed significant improvements in anxiety, depression, general diet, exercise and frequency of checking blood sugars.
Ismail 2018 UK	Two arm, single-blind, parallel, Cluster RCT Measures collected at: Baseline - HbA1C - BP - BMI - Cholesterol	N=334 Type 2 diabetes >2yrs IG: n=164, mean age 59yrs, female 50%. CG:	Primary Care Setting Diabetes Specialist Nurse with/without D6 training. 12 sessions/ 12 months	IG: Diabetes Specialist Nurse with specific D6 (active listening, managing resistance, directing change, supporting self-efficacy, addressing health beliefs, and shaping behaviours) training delivered	Face to face delivery in routine primary care clinics. One to one	• *HbA1c at 18mths.* • BP, • BMI, • Cholesterol • Fasting Triglycerides • waist circumference, • PHQ-9,	No significant difference in HbA1c at follow up in the IG compared with the CG. No significant effects of the intervention on the secondary outcomes including BMI, BP, Fasting triglyceride or psychological distress.

Appendix 1: Data Extraction Table

First author, year, location	Study type	Sample: No., mean age, sex, (diabetes duration)	Setting (duration); No./length of sessions	Intervention; Content	Format; Delivery Method	Main Outcomes Time of Measures	Main Results
	- Fasting Triglycerides - PHQ-9 - DDS 18mth follow-up - HbA1C - BP - BMI - Cholesterol - Fasting Triglycerides - PHQ-9	n=170, mean age 58.9yrs, 52% female.	IG: Standard care and D6 intervention CG: standard care 18mth follow up	standard care plus Diabetes-6 (active listening, managing resistance, directing change, supporting self-efficacy, addressing health beliefs, and shaping behaviours). 12 sessions x 30mins each. CG: Diabetes Specialist Nurse delivered standard care – diabetes self-management education, monitoring of biomedical status and giving clinical information and advice. 12 sessions x 30mins.		• AUDIT - harmful alcohol intake, • DDS - diabetes specific distress.	
Wagner 2016 USA	RCT	N = 105	Community based organisation	Community Health Worker	Face to face delivery,	• *HbA1c* baseline, post-treatment and	Depressive symptoms decreased in IG yielding a medium effect size.

Appendix 1: Data Extraction Table

First author, year, location	Study type	Sample: No., mean age, sex, (diabetes duration)	Setting (duration); No./length of sessions	Intervention; Content	Format; Delivery Method	Main Outcomes Time of Measures	Main Results
	Measures collected at: Baseline: - HbA1C - Cortisol (Urine sample) - PHQ-8 (PHQ-9 minus suicidality item) - PROMIS-SF8A - PAID-5 - Self-reported health status. Post Treatment: - HbA1C - Cortisol (Urine Sample) - PHQ-8 (PHQ-9 minus suicidality item) - PROMIS-SF8A - PAID-5 - Self-reported health status. 3mth Follow-up:	Type 2 diabetes >6mths IG: n=61 Mean age 60yrs, female 74% CG: n=46 Mean age 60.8yrs, female 72%	IG: 8 group sessions of diabetes education + stress management delivered by community health workers. CG: 1 group session usual care diabetes education delivered by community health workers 3mth follow up	IG: 2.5hr diabetes education group + 8 group sessions including: stress management, psychoeducational skills training and physical relaxation training (PMR and thermal biofeedback). CG: 2.5 hr diabetes education group covering info about diabetes and its management, nutrition, medications, physical activity and self-monitoring of blood glucose.	group intervention	3mth follow-up. • PHQ-8 (PHQ-9 minus suicidality item) • PROMIS-SF8A • PAID-5 • Self-reported health status.	A significant change in both anxiety symptoms, and self-reported health in IG. Diabetes distress decreased over time but was not significant. No significant change in HbA1c in either group. Decreases in cortisol were found in the IG, however were not significant. Dose response effect evident in HbA1c with more tress management sessions attended leading to improved glycaemic control and diabetes distress.

Appendix 1: Data Extraction Table

First author, year, location	Study type	Sample: No., mean age, sex, (diabetes duration)	Setting (duration); No./length of sessions	Intervention; Content	Format; Delivery Method	Main Outcomes Time of Measures	Main Results
	- HbA1C						

Empirical Paper 1

The 'Cart before the Horse' –
A retrospective exploration of the barriers and facilitators to implementing health behaviour change skills in clinical practice.

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Abstract

Objectives

The aims of this study were to explore, using the Theoretical Domains Framework (TDF) and the Behaviour Change Wheel (BCW), what the barriers to implementation were, following previous training in Health Behaviour Change Skills in a local Specialist Diabetes Team.

Design.

Qualitative Interview Study.

Methods

Semi-structured interviews were conducted with patient-facing health care professionals working in a diabetes team, 36 months following their participation in Health Behaviour Change Skills training. The Theoretical Domains Framework (TDF) informed a framework analysis in which findings were mapped onto the Behaviour Change Wheel (BCW).

Results

The health-care professionals who participated understood the importance of behaviour change interventions (beliefs about consequences) and felt that they had the capabilities to facilitate behaviour change with patients (beliefs about capabilities). However, some were reluctant to discuss behaviours, perceived as unrelated to the patient's visit (social/professional role and identity). Discipline- specific tasks were prioritised and delivering behaviour change interventions was perceived as psychologically burdensome. Time required to develop their skills in this area, as well as workload pressures (environmental context and resources), were highlighted as potential barriers to implementing health behaviour change skills in clinical practice.

Conclusions

Across disciplines involved in diabetes care, health care professionals see the value of delivering behaviour change interventions. Barriers to implementing behaviour change skills related to workload, clinical environment and perceptions of the health care professional role must be addressed, using appropriate intervention functions and behaviour change techniques (BCTs) in order to support health care professionals to increase the delivery of health behaviour change interventions in routine practice.

Introduction

Health behaviour change is a medical issue of world-wide importance (World Health Organisation, 2017). There is a growing body of evidence that unhealthy behaviours are risk factors for long-term conditions such as diabetes, cardio-vascular disease and cancer (World Health Organisation, 2017). Internationally and regionally, public health strategies are emphasizing the need for greater focus on preventative strategies (Department of Health, 2016; Public Health England, 2016).

Health-care professionals have the opportunity to facilitate behaviour change with patients through the nature of their re-occurring one-to-one contacts. This type of opportunistic behaviour change intervention has been the subject of investigation in recent years (Keyworth, 2020), and it is clear that healthcare professionals are a trusted source of health behaviour change advice (McPhail, 2012). In addition, patients often welcome health behaviour change advice during other healthcare consultations which are not necessarily focused on health behaviour (Aveyard et al., 2012). Despite having maximum reach if delivered by patient facing health-care professionals, health behaviour change interventions can be perceived as taking too much time in a consultation (Heslehurst, 2014). This is in contrast to (Aveyard, 2016) who identified that behaviour change interventions can be delivered in as little as 30 seconds. However, health behaviour change delivery is a relatively new expectation of health care providers and, as such, may not be a part of established health professional training.

The Theoretical Domains Framework (TDF) is used in implementation studies to assess and address factors that impact on behaviour – in this case the integration of

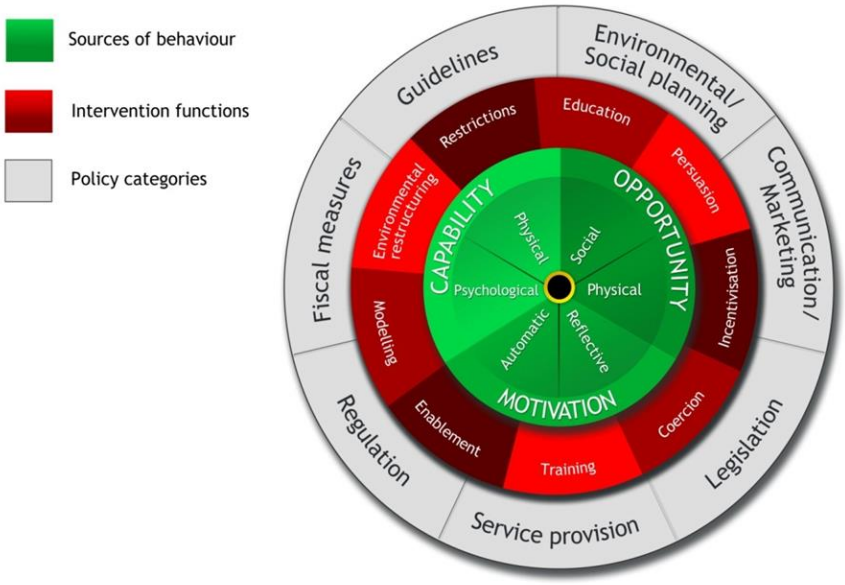
behaviour change skills. It simplifies 33 theories which can explain behaviour change in 14 domains: 1) knowledge, 2) skills, 3) social/professional role and identity, 4) beliefs about capabilities, 5) optimism, 6) beliefs about consequences, 7) reinforcement, 8) intentions, 9) goals, 10) memory, attention, and decision processes, 11) environmental context, 12) social influences, 13) emotion, and 14) behavioural regulation (Cane, 2012), which can be used to identify a wide range of factors that might influence behaviours as well as desired behaviour changes.

The COM-B model (Michie, 2011a) recognises that behaviour is part of an interacting system and summarises the TDF further into three key domains; 1) capability, 2) opportunity, and 3) motivation (Michie, 2011a; Atkins et al., 2017). Any behaviour change intervention needs to initiate a change in one or more of these components to create a new behaviour. The COM-B model (Michie, 2011a) then forms the central component of the Behaviour Change Wheel (BCW) (Michie, 2014) as can be seen in Figure 1 below.

The BCW can then be utilised to design interventions that address those factors targeting the various components of a desired behaviour. These potential interventions include areas such as education, training, restrictions, persuasion and incentives, and map onto the outer aspect of the BCW, which identify seven policy areas that can support in the delivery of these interventions at a wider population level. Defining specific behaviour change techniques, such as those listed in the behaviour change wheel, may help to clarify the active components of behaviour change training that facilitate implementation into practice, allowing training to be replicated and enable evaluations of such training.

It was identified that, although previous health behaviour change training (McCrossan, 2017) delivered by the principal investigator in a local NHS Trust was acceptable, institutional constraints may be a barrier to implementation. This study seeks to understand these barriers further by utilising both the Theoretical Domains Framework (TDF) (Cane, 2012) and the COM-B model (Michie, 2011a) to allow identification of the domains that require greater attention. It is hoped that this greater understanding of the barriers will allow such training to proceed to implementation in clinical practice in the future.

Figure 1: The Behaviour Change Wheel (Michie, 2011a)



Aims

The aims of this study were to explore, using the TDF and BCW, what the barriers to implementation were, following the previous training (McCrossan, 2017) in Health Behaviour Change Skills in a local Specialist Diabetes Team. Identification of the domains in which the barriers exist will allow the training to be refined/redesigned to allow wider implementation across the team, minimising staff stress while improving patient self-management skills.

Method

Design

A qualitative study using semi-structured interviews with patient-facing health care professionals working in a local NHS Trust was conducted. Two theory-based tools for understanding behaviour, the COM-B model (Michie, 2011a) and the Theoretical Domains Framework (Cane, 2012) were employed to illustrate how the qualitative findings can be utilised to inform behaviour change training for health-care professionals in a specialist diabetes team. The TDF is a framework that examines the psychological factors of behaviour change through 84 constructs in 14 different domains, which can be further distilled into 3 domains as evidenced in the Behaviour Change Wheel (see Figure 1). TDF interview guides previously used by Squires (2013;

2014) were used to inform interview topics. The topic guide (presented in Table S1) was informed by the fourteen-domain TDF (detailed in Table 2) prompting both exploration and detailed analysis of environmental, social, cognitive and affective influences on health care professional practice (Cane, 2012). Using the TDF to tailor the interview questions allowed: 1) for structuring of the emergent themes that were generated from the data, and 2) the ability to link the respective components of both the COM-B model and the TDF. These were then mapped onto the Behaviour Change Wheel (BCW) (Michie, 2011b; Michie, 2011a), allowing identification of where the barriers or enablers associated with implementing health behaviour change interventions lie in the COM-B model.

Sample

Purposeful sampling was to recruit participants who had previously participated in a previous health behaviour change training. The previous (2017) health behavior change training was delivered to 18 specialist diabetes patient facing staff working in a local NHS Trust. The 18 participants involved in the initial study were invited to participate in this study. Participants who expressed an interest were invited to supply their contact details so that a convenient time could be arranged to conduct the interview. There was a 22% response rate (four participants), which is in keeping with previous TDF-based interview studies where low recruitment rates have also been exhibited (Duncan et al., 2012; Curran, 2013).

Procedure

Ethical approval for the study was obtained from a university ethics committee (ref: 20/NSP/022). Based on the literature (Michie, 2014), three recommendations were followed when conducting the interviews: 1) Open – ended questions were employed to encourage participants to explore their professional practice and identify any barriers that influenced their implementation of health behaviour change skills into practice, 2) an interviewer with previous experience in conducting qualitative interviews with health care professionals conducted the interviews, and 3) participants were encouraged to think about instances of current or recent practice of implementing health behaviour change skills in the diabetes clinic. Data collection took place between October 2020 and December 2020.

Analysis

Theory-based content analysis was conducted in four distinct stages: coding, generating belief statements/themes, linking themes to relevant theoretical domains, and mapping themes. Two researchers (TMcC and JG) independently coded the participant responses using a directional approach to content analysis (Hsieh, 2005) and QSR Internationals NVivo 11 software (QSR International Pty Ltd., 2020).

The transcripts were reviewed in tandem to gain a sense of the data and then a directed content analysis approach (Hsieh, 2005) to break the data down (chunk) into small units was employed, using the 14 domains of the TDF as coding framework. Common belief statements that suggest an influence on behaviour skills implementation (Francis, 2012) were then generated. These were reviewed for accuracy and then grouped into broader themes/sub-themes. As in previous studies (Francis, 2009; Islam, 2012; Squires, 2015), TDF domains are seen as important to behaviour skills implementation if (1) they contained multiple themes/subthemes, (2) conflicting themes/subthemes existed for that domain, or (3) the themes within the domain were identified as having a strong impact on behaviour skills implementation (crossed multiple domains). Finally, the identified domains and major themes were mapped onto the COM-B model and consequently the Behaviour Change Wheel (BCW). The relevant themes identified through the TDF analysis were then linked with intervention functions and policy options that may be used to inform future intervention design (Michie, 2014).

Results

Participants (n=4), represented three disciplines (Community Diabetes Specialist Nurses (n=2), Podiatrist (n=1) and Dietician (n=1) involved in patient-facing diabetes care. They worked across both community (n=2) and acute (n=2) settings and were all female. Length of interviews ranged from 35 – 95 min (mean length 65min).

Results are categorised into themes, theoretical domain and COM-B in Table 1, with key findings mapped to BCTs in Table 2. Five theoretical domains emerged that explained the barriers and enablers to delivering health behaviour change interventions within this group: environmental context and resources (n=30

occurrences; reported by 4 [100%] of the 4 health-care professionals), social influences (n=16 occurrences; reported by 4 [100%] of the this group), emotion (n=15 occurrences; reported by 4 [100%] of this group), social/professional role and identity (n=14 occurrences; reported by 4 [100%] of this group) and beliefs about capabilities (n=11 occurrences; reported by 4 [100%] of the health-care professionals). Explanatory quotes with participant ID are presented with health-care professional categories displayed in Table 2.

Table 1. The barriers and enablers to delivering behaviour change in a Diabetes Specialist Team (*those in bold are the main themes*).

COM-B	**Capability**	**Opportunity**		**Motivation**		
		Physical	Social	Automatic	Reflective	Reflective
TDF Domains		Environmental Context	Social Influences	Emotion	Social/Professional role and Identity	Beliefs about Capabilities
Explanatory Themes		**Time Pressures (Barrier)** Health Behaviour Change not prioritised (Barrier) Workload Pressures (Barrier) Need for practical technique (Barrier) Time to learn and practice new skills (Barrier)	**Perceived support of Colleagues (enabler)** **Importance of whole team approach (enabler/barrier)**	**Stress (Barrier/ Enabler)**	**Discipline Specific Focus (Barrier)**	**Perception that knowledge and skills are good, confidence high (Enabler)** **Awareness that using HBC can increase confidence and reduce stress. (Enabler)**

Table 2. Summary of key findings mapped to intervention functions and BCT's according to Michie (2014)

COM-B domain	TDF domain	Description of domain	Exemplar quotes	Intervention function	Individual BCT's
Physical Opportunity	**Environmental context and resources.** Any circumstances of a persons situation or environment that discourages or encourages the development of skills and abilities, independence, social competence and adaptive behaviour.	The environment should be conducive to delivering behaviour change interventions, with the time provided to learn and implement new techniques.	"I think that the fact that there is a specialist diabetes team means that the intention was that as a specialist service we would have more time to address all aspects of diabetes including behaviour change. The difficulty is that the clinics are still oversubscribed so there's never enough time to do everything we would like to." ([redacted] …negative aspects are time taken to learn new skills, i.e catch up on the time out of clinic. ([redacted]	• Persuasion • Incentivisation • Environmental Restructuring	• Information about emotional consequences • Incentive • Restructuring the physical environment
Social Opportunity	**Social Influences**. Those interpersonal processes that can cause individuals to change their thoughts, feelings or behaviours.	The influence that those in our immediate environment can have on the implementation of health behaviour change.	"…definitely so much easier if your colleagues and lead clinicians are supportive." [redacted] "I do think it would be so much easier if everyone from practice managers, gps, consultants etc were all focusing on health behaviour change skills too." ([redacted]	• Persuasion • Restrictions	• Action Planning • Using rules to increase HBC implementation
Automatic Motivation	**Emotion.** A complex reaction pattern, involving experiential, behavioural, and physiological elements, by which the individual attempts to deal	Delivering health behaviour change interventions can have an emotional impact on both staff and patients.	"Personally if I have less frustration, that's less stress, which means I'm going home with a clearer head – that's a good incentive." ([redacted] "…if frustrated and stressed I probably work from auto-pilot	• Persuasion	• Information about emotional consequences

	with a personally significant matter or event.		rather than think about HBC." [redacted]		
Reflective Motivation	**Social/Professional Role and Identity.** A coherent set of behaviours and displayed personal qualities of an individual in a social or work setting.	Importance of the medical aspects of care.	"It doesn't feel like there's ever enough time for any of the task we need to do and the focus has to be on medical aspects like HbA1C, it can leave little time for focusing on behaviour change in the way you might want to." ([redacted] "…if it's a really complex case I'm probably more likely to focus on the medical priorities ([redacted]	• Education • Environmental Restructuring	• Habit Formation • Providing prompts/cues
	Beliefs about Capabilities. Acceptance of the truth, reality, or validity about an ability, talent, or facility that a person can put to constructive use.	Perception that the knowledge and confidence to deliver health behaviour change is in place.	"Fairly confident (in delivering HBC). I know when the clinic is quieter or after I've come back from some leave I'm refreshed and I can easily implement behaviour change skills." ([redacted] "When you have been able to use it more you do feel more empowered and it increases your confidence to use it with the next patient." ([redacted]	• Education • Environmental Restructuring	• Verbal persuasion about capability • Restructuring the physical environment

Environment Context and Resources

This domain highlighted one major barrier to implementing health behaviour change interventions. There were overlaps with the Social/Professional Role and Identity domain. The health-care professionals involved described the pressures that they face when attempting to deliver health behaviour change interventions, as well as emphasising the need for access to appropriate refresher training, identifying quick, practical behaviour change techniques.

Participants perceived several barriers in relation to workload. They described a desire to implement health behaviour change interventions but felt they were not supported organisationally. On exploring these further, the main theme emerging was that of time pressures, with 4 sub-themes illustrating this more clearly.

Time Pressures (Barrier)

Participants reported already feeling under considerable time pressure to conduct clinics addressing patients' primary medical problem. This meant that despite having both the skills and knowledge required to deliver health behaviour change interventions, they felt unable to find the time in their existing consultations to implement these.

> I think that the fact that there is a specialist diabetes team means that the intention was that as a specialist service we would have more time to address all aspects of diabetes including behaviour change. The difficulty is that the clinics are still oversubscribed so there's never enough time to do everything we would like to do. [redacted]

They also described how *Health behaviour Change was not Prioritised,* feeling that they needed to focus on medical aspects of care instead. This overlaps with the Social/Professional Role and Identity domain and highlights the perceived lack of support from both senior management and the healthcare system generally.

> We have 30 min slots and by the time we have addressed the medical side of things, there's little time for anything else." [redacted]

Participants also detailed *Workload Pressures* as a sub-theme, stating that the demands on specialist staff are varied, involving assessment, management and engagement of patients as active participants in managing their condition. This means that consultations are already packed with other required activities and they can have little space left to add in the delivery of health behaviour change interventions. This additional pressure, both physically and psychologically, impacted health care professionals' motivation and morale and left them feeling a lack of organisational support.

> Frustration – could do so much more if I had the time. ([redacted]

Finally, participants described that *Time to learn and practice new skills* was welcomed however they reported that while time was granted to attend training, they had to reschedule clinics to allow this. That resulted in busier clinics either before or after their training, which ultimately increased stress levels, and allowed little time to start implementing new techniques on their return to work. Techniques that felt required intensive input to deliver effectively, therefore were not practical for implementation in a busy clinic. They reported a belief that there was a *Need for practical techniques* that were brief, and that these would aid delivery and thus increase their confidence generally in implementing health behaviour change.

> …need more practical, quick techniques to be able to start implementing any aspect of health behaviour change. [redacted]

> …negative aspects are time taken to learn new skills, i.e. have to catch up on time out of clinic….putting the skills into practice will take longer initially as well as may be difficult and tiring. [redacted]

Social Influences

Two enablers and one barrier were described in relation to the domain Social Influences. Health-care professionals involved believed that the support of staff was important in assisting them in both implementing and sustaining health behaviour change interventions. Additionally, they described the influence that more senior

members of staff may have on their decision to implement health behaviour change interventions.

Perceived Support of Colleagues (Enabler)

Health-care professionals reported that peer support enabled them to implement health behaviour change interventions and made the experience much easier. They described that joint clinics with other professions made them more likely to implement health behaviour change, unfortunately, they did not elaborate on this, however it is speculated that working with others offers a greater degree of accountability, which facilitates implementation.

> …definitely so much easier if your colleagues and lead clinicians are supportive. [redacted]
>
> Joint clinics with other health professionals can help. [redacted]

Importance of whole team approach (Enabler/Barrier)

The whole-team approach was something that all 4 participants highlighted as something that could either support or undermine the implementation of health behaviour change interventions. Participants reported that involving the entire MDT was important and stated that "*when we did psychology training previously it was really great to see one of the consultants there too*" (Dietician). They described that without support of senior staff they saw little point in implementing health behaviour change interventions.

> It has to come from the consultants down; if they don't support it, there's no point. [redacted]
>
> I do think it would be much easier if everyone from practice managers, GPs, consultants etc were all focusing on using health behaviour change skills too. [redacted]
>
> ….greater MDT (psychology) input required. [redacted]

Emotion

One barrier, namely stress, was identified in relation to the emotion domain; however, it was also identified as an enabler. Participants reported that they were more likely to implement health behaviour change interventions when they were less stressed. They identified that while implementing health behaviour change interventions could initially increase their stress; in situations where it had been effective, it had lowered the stress levels of both the professional and the patient. In situations where this occurred, health-care professionals reported that they were more encouraged to implement health behaviour change interventions as a result.

***Stress (Barrier/Enabler*)**

Health-care professionals meet increasing demands on their time and skills on a regular basis. As a result, they describe increasing stress levels as they struggle to meet the needs of the service and maintain best practice for their patients. Implementing strategies that are new to their practice increases the demands on them physically and psychologically. However, there was an awareness that in instances where health behaviour change interventions had been implemented successfully, this had a positive impact on stress. As a result, while it was seen initially as a barrier, it was also highlighted that it could, in the longer term, be an enabler to implementing health behaviour change interventions.

> It's tough to keep thinking about the long-term benefit when you're stuck in the middle of a tough clinic trying to do something unfamiliar. [redacted]
>
> Going home less stressed is a big incentive. (CDSN1)
>
> If I was able to use health behaviour change skills with patients more often I think both the patient and me would be less frustrated and stressed. [redacted]

Social/Professional Role and Identity

One barrier was identified in this domain. Health-care professionals believed that a specialist role could potentially act as a barrier to implementing health behaviour change interventions when this was perceived as not part of that defined specialist role. Furthermore, the fact that other specialist staff within the team were perceived to have greater skills in this area, meant that implementing health behaviour change interventions was often seen as the role of one specific profession.

Discipline Specific Focus (Barrier)

Health-care professionals reported that they felt the culture of the team they worked within determined whether behaviour change was discussed as part of the day to day practice. The nature of specialist roles meant that each profession tended to focus on their immediate professional specialism with responsibility for behaviour change being seen as the realm of the psychologist only.

> …if there is something medically that requires attention it can be a real struggle to try and bring in health behaviour change. [redacted]
>
> …but nurses can't do everything, [redacted]

Beliefs about capabilities

Two enablers were described in relation to the domain beliefs about capabilities. Health-care professionals believed that they had the basic knowledge and had gained the skills required, which translated to improved confidence in their ability to deliver health behaviour change interventions. This was in stark contrast to the barriers identified in the environmental context and resulted in increased frustration and stress as a result.

Perception of knowledge and skills being good (Enabler)

Participants described the previous training they had attended as increasing their knowledge and skills regarding behaviour change skills. They felt that implementation was not related to beliefs about their capabilities as confidence levels were high but was more related to time/workload pressures.

> (I am) 100% confident (in implementing health behaviour change interventions) if I had the time. [redacted]
>
> …fairly confident when I have enough time. [redacted]

Awareness that implementation of HBC will increase confidence and reduce stress (Enabler)

Health-care professionals reported that in situations where they had been able to implement behaviour change interventions, they noticed increased confidence and reduced stress levels as a result.

> When you (I) have been able to use it (health behaviour change) more you do feel more empowered and it increases your confidence to use it with the next patient. [redacted]

Discussion

There were few inconsistencies across the three professional groups represented, and this study explains these using a theoretical framework specifically focusing on implementation (Cane, 2012; Atkins et al., 2017). The five prominent TDF domains that provide greatest insight into the challenges faced by the health-care professionals were described and will allow for the development of more focused training with implementation in clinical practice at the forefront.

Previous literature has also identified time and workload pressures as preventing the implementation of health behaviour change interventions (Um, 2013; Elwell, 2014). The other important finding is consistent with Keyworth et al. (2019) who found that behaviour change interventions are not given priority as part of clinical practice

across health-care disciplines. Health-care professionals described feeling that their specialist role allowed them to deal with the primary complaint only and that delivering behaviour change interventions was not necessarily part of their remit (*beliefs about capabilities*). They reported high levels of confidence in their knowledge and skills around health behaviour change interventions however felt that external constraints, such as time pressures and support of senior management, prevented their implementation in clinical practice. McPhail (2012) found that healthcare professionals are both an expected and trusted source of health behaviour change advice, therefore it is important that where possible we utilise this valuable resource.

It appears that despite having good confidence in the ability to implement health behaviour change interventions, health -care professionals require several elements to be able to translate this knowledge and skills into clinical practice. Elements such as: 1) Organisational support, in the provision of reduced clinic lists to allow staff the time to both train/upskill and practise their skills; 2)Organisational support to encourage all levels of staff to embrace and incorporate the delivery of health behaviour change in their practice, and thus offer ongoing peer support within the teams for implementation; 3) Policy change to address the changing nature of healthcare from an educational viewpoint and encourage health care professionals to consider patients in a broader, more holistic context, to deal with not only the management of presenting and continuing problems, but in the routine delivery of health behaviour change interventions.

Implications for Practice/Implementation

The findings from this study suggest that supporting health-care professionals to deliver behaviour change interventions requires greater input on all levels. While public health strategies are emphasising the need for greater focus on preventative strategies (Department of Health, 2016; Department of Health, 2016; Public Health England, 2016), the cultural, educational and organisational changes have not been put in place to support this. The scope of this study was limited and explored, using the TDF, the COM-B model, and ultimately the Behaviour Change Wheel (Michie, 2014) which factors (Capability, Opportunity, or Motivation) may have been

overlooked in a previous training aimed at giving staff the knowledge and skills required to implement health behaviour change interventions. What it has identified is that the previous training, developed using several health behaviour change theories, as well as previous experience, neglected to consider the COM-B model. This retrospective study has highlighted that the previous health behaviour change training provided the health-care staff involved with the capability to deliver health behaviour change interventions. However, it assumed that both the opportunity and motivation to implement behaviour change interventions existed within the team and therefore the organisation, and this was not the case. Employing the COM-B model from the outset would have identified these barriers and guided a much more robust training programme addressing these areas. The COM-B provides a model which can be used by non-specialists to design behaviour change interventions, which are not only insightful and systematic, but rigorous and standardised, and target all relevant areas from policy to skills and knowledge required from the outset. This allows for the development and delivery of more cost-effective training that would facilitate direct implementation into clinical practice.

Recommendations

The COM-B model and the BCW provide a framework for designing and evaluating behaviour change interventions. While neither were employed in the previous development of the (2017) HBC training, they provided a standardised guide for the evaluation described here. Using this evaluation facilitates the development of a more robust HBC intervention.

According to the BCW, the first step in designing an intervention is to define the problem in behavioural terms (Michie, 2014). Despite, having the capability to implement behaviour change interventions, the staff involved in this study were not doing so on a routine basis. Therefore, the behaviour of interest here is the routine use of behaviour change interventions in daily clinical practice.

This evaluation has provided us with the knowledge that staff work within a time pressured environment, with a range of competing demands. The second step of the BCW process then is to identify a target behaviour which could address the

behavioural problem and Michie (2014) suggest using the criteria below to identify which behaviour to target:

- Likely Impact
- Ease of implementation
- Likely Spill over
- Ease of measurement

Applying these criteria suggests that intervention development should focus on seven behaviours: Instruction on how to deliver brief behaviour change interventions; behavioural practice/rehearsal of behaviour change interventions; feedback on behaviour; self-monitoring; providing prompts or triggers for behaviour change intervention use; developing a plan to promote routine behaviour change intervention use; and providing information about the benefits of routine behaviour change intervention implementation. This study has shown that these behaviours are not currently taking place in the diabetes clinic, but that they may be reasonably easy to implement. Patient behaviour is likely to be directly influenced by changing these health-care professional behaviours (Légaré, 2010; Lally, 2013; Barker, 2016) and measurement of this change should be reasonably easy.

The third step of the BCW requires detailing the specifics of who will perform the target behaviours, what exactly they need to do in order to achieve change, where they need to do it and when, how often they need to do it and if necessary who else may be required to support the behaviour change. This detail is outlined in Table 3 below.

The final step is to use the COM-B model (as we have done) to explore if the diabetes team have the capability, opportunity and motivation to implement behaviour change interventions on a routine basis. Staff working within the specialist diabetes team illustrate through clinical practice that they currently have the physical and psychological capability to implement behaviour change interventions routinely. What this study has highlighted is that they currently lack the physical opportunity and elements of both automatic and reflective motivation which would enable them to fully implement routine behaviour change intervention into their clinical practice.

Using this information, Table 3 below illustrates a potential behaviour change intervention which addresses the barriers highlighted in this study.

Table 3. Target Behaviours in the Context of BCTs and COM-B model

Target Behaviour	BCT	COM-B domain	Who	What	When	Where
Instruction on how to deliver brief behaviour change interventions	Restructuring the Physical environment.	Physical Opportunity	Psychologists Diabetes MDT	Presentation, case discussion and written information	During MDT meetings	Meeting Rm
Behavioural practice/rehearsal of behaviour change interventions	Restructuring the physical environment. Habit Formation	Physical Opportunity Reflective Motivation	Psychologists Diabetes MDT	Role Play in MDT meeting Practice in Clinic.	MDT Meeting Clinical encounter	Meeting Rm Clinic Rm
Feedback on behaviour	Habit Formation	Reflective Motivation	Psychologists Diabetes MDT	In role play Patient Feedback	MDT Meeting Clinical encounter	Meeting Rm Clinic Rm
Self-Monitoring	Incentive	Physical Opportunity	Diabetes MDT	Record BCTs used at each contact	Clinical Encounter	Clinic Rm
Providing prompts or trigger for behaviour change intervention use	Providing prompts/cues	Reflective Motivation	Psychologists Diabetes MDT	Collaboration to develop a prompt sheet for clinical notes	MDT meeting Clinical encounter	Meeting Rm Clinic Rm
Developing a plan to promote routine behaviour change intervention use	Restructuring the physical environment	Physical Opportunity	Psychologists Diabetes MDT	Collaborate to develop an action plan for use in clinic	MDT Meeting Clinical encounter	Meeting Rm Clinic Rm
Providing Information about the benefits of routine behaviour change intervention implementation	Information about emotional consequences	Physical Opportunity Automatic Motivation	Psychologists Diabetes MDT	Reflective Practice sessions	MDT Meeting	Meeting Rm

Strengths and Limitations

These findings lend further support to the effectiveness of using the COM-B model to design, develop and evaluate a behaviour change intervention based on theory and applicable to health care professionals and patients alike. The sampling in this study was restricted, however provided views from three different professional groups working in unique roles within the specialist diabetes team. The theoretical framework allowed these views to be synthesised and common barriers and enablers across all professions involved were identified.

Findings must be considered alongside workload pressures, particularly at the time of this study. At the time of this study the nation found itself in the middle of a

pandemic and this must be considered as it will undoubtedly have had an impact on increased workloads in this specialist team. The poor recruitment rate may also be attributable to the impact of the pandemic, with many staff redeployed or shielding and others having reached capacity at both a physical and psychological level. However, sample size was small, and restricted to one healthcare trust, therefore, any conclusions drawn cannot be incautiously generalised.

The analysis employed here focused on identifying the most prominent theoretical domains across the professional groups deemed to be important enablers or barriers to delivering interventions. However, different methods for identifying domain importance may yield additional theoretical domains of importance (Francis, 2014) and the challenges of using the TDF framework (Cane, 2012).

Conclusion

As previously identified (Public Health England, 2016) the health-care professionals involved are willing and aware of the benefits of implementing health behaviour change interventions as part of their daily practice. The participants of this study were able to identify several difficulties they encountered when attempting to implement health behaviour change interventions. Using the TDF as an interview guide has enabled identification of the key theoretical domains associated with implementation of health behaviour change interventions in clinical practice for this team. Mapping these domains onto the COM-B model ensures that all three domains required to create behaviour change are targeted. This allows the development of a more strategic training programme encompassing all the domains involved, to address the barriers identified, resulting in a more efficient delivery of training which will ultimately be implemented into clinical practice. The design and implementation of any further behaviour change interventions be they at organisational or clinical level should consider fully the merits of applying the COM-B model from the outset to enable best use of resources and allow for systematic and standardised evaluation, and avoid putting the ‘cart before the horse’.

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Appendix 1: Table S1. The Interview Topic Guide categorised in both the COM-B and Theoretical Domains Framework. Definitions from Cane et al. (2012)

COM-B Domain	TDF Domain	Definition	Interview Topic Guide
Capability: Psychological	Knowledge	An awareness of the existence of something	1)What do you know about health behaviour change skills? 2)Do you believe that you have a strong enough knowledge base to implement new behaviour change skills into practice?
	Behavioural Regulation	Anything aimed at managing or changing objectively observed or measured actions	1)Do you expect to implement behaviour change skills? IF YES: Why? What will help you following through with using health behaviour change skills? If NO: Why? What usually prevents you from following through with integrating skills learned in training? 2)What steps could you take to implement health behaviour change skills? 3)If you wanted to encourage the implementation of health behaviour change skills at a team or practice level, what would be the necessary steps?
	Memory, Attention and Decision Processes	The ability to retain information, focus selectively on aspects of the environment and choose between two or more alternatives	1)Is it an easy decision to use health behaviour change skills in your practice or something that you struggle with and think about with every case? Can you provide more information or give an example of where this was the case? 2)Do you need to consciously think about when to implements health behaviour change skills in your practice or is it automatic or a combination of both (semi-automatic)?
Capability: Psychological Physical	Skills	An ability or proficiency acquired through practice	1)Which health behaviour change skills do you regularly use in your diabetes clinic? 2)How confident are you in guiding a patient in health behaviour change?
Motivation: Reflective	Social/Professional Role and Identity	A coherent set of behaviours and displayed personal qualities of an individual in a social or work setting	1)What is your role within the diabetes team? 2)Does your role within the specialist diabetes team allow you time to focus on supporting people with health behaviour change?
	Beliefs about Capabilities	Acceptance of the truth, reality, or validity about an ability, talent, or facility that a person can put to constructive use	1)How easy or difficult is it to use health behaviour change skills in your practice? a.If difficult, what issues have you encountered that makes using health behaviour change skills in your practice problematic?

			b.If easy, what has helped in making it easy to use health behaviour change skills in your practice? 2)How confident are you in your ability to implement health behaviour change skills in your practice? 3)Does that influence how often you might use these skills?
	Optimism	The confidence that things will happen for the best or that desired goals will be attained)	1)Do you believe that implementing health behaviour change skills in your practice is essential to reach best practice in diabetes management?
	Beliefs about Consequences	Acceptance of the truth, reality, or validity about outcomes of a behaviour in a given situation	1)What do you think might happen if you incorporate health behaviour change skills in your practice, both positive and negative? (Prompt: in relation to patient care, for yourself, for diabetes management, can be both short and long term) 2)Do you believe the negative aspects of implementing health behaviour change skills are worth the benefits? Why or why not? Note: "negative aspects" can be financial but also more subjective (ex. Time it takes to learn an implement)
	Intentions	A conscious decision to perform a behaviour or a resolve to act in a certain way	1)Do you intend to use health behaviour change skills in your practice?
	Goals	Mental representations of outcomes or end states that an individual wants to achieve	1)Considering other priorities, you may have, how important is it that you use health behaviour change skills in your practice? a.How would you rate it on a scale of 1-10, where 10 is most important? Why did you give that score? 2)Do you want to implement health behaviour change skills?
Opportunity: Physical	Environmental Context and Resources	Any circumstance of a person's situation or environment that discourages or encourages the development of skills and abilities, independence, social competence, and adaptive behaviour	1)What aspects of your clinical settings influence whether you implement health behaviour change skills? 2)Are there competing tasks or time constraints that might influence whether or not you implement health behaviour change skills?
Opportunity: Social	Social Influences	Those interpersonal processes that can cause individuals to	1)Would any other team members influence whether or not you implement health behaviour change skills?

		change their thoughts, feelings, or behaviours	2)Does the patient or their family influence whether or not you implement health behaviour change skills? (i.e., do their expectations influence whether or not you implement health behaviour change skills)
Motivation: Automatic	Emotion	A complex reaction pattern, involving experiential, behavioural, and physiological elements, by which the individual attempts to deal with a personally significant matter or event	1)When you think about implementing health behaviour change skills, how do you feel (e.g. anxiety in having to learn a new procedure, worried about the learning curve, frustrated with the amount of research to keep up with, worried about patient outcomes if you switch to a less familiar method, etc.)? 2)Do your emotions ever influence implementing health behaviour change skills? (e.g. you're tired and so you stick with the procedure you're comfortable with, that patient is in bad shape and you want to stick with the method you know, etc.)
	Reinforcement	Increasing the probability of a response by arranging a dependent relationship, or contingency, between the response and a given stimulus	1)Are there any personal or external incentives to implementing health behaviour change skills? (e.g. seeing my patients better able to manage their diabetes after using health behaviour change skills as an incentive?) 2)Have there been any experiences (either good or bad) in your past practice that influence whether you use health behaviour change skills now?

Empirical Paper 2

The Use of Hypnotherapy in the Treatment of Needle Phobia in an Adult with Type 2 Diabetes.

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Abstract

This is a single case study of an adult male with needle phobia and Type 2 Diabetes (T2DM). Treatment consisted of a brief hypnotherapy intervention which focused on needle phobia. The Hospital Anxiety and Depression Scale and the Patient Anxiety In Diabetes–5 scale were used to assess changes in mood across three time points from baseline to 3-month follow up. Physiological measures were also tracked to identify any impact on blood glucose levels in the form of HbA1c (which is a blood test that provides information on blood glucose levels over a period of 3 months), which give clear indicators of treatment adherence and self-management. Following four intervention sessions and two follow-up sessions, a positive impact was observed on needle phobia symptoms. This was reflected in decreased scores in self-report measures from baseline to end of treatment and these were sustained at follow-up. HbA1c also indicated that treatment adherence had improved from baseline to end of treatment and continued to improve when measured again at 3-month follow-up. This single case study suggests that hypnotherapy may be an effective intervention in the treatment of needle phobia, however further studies are required.

Keywords

Hypnotherapy, needle phobia, type 2 diabetes, anxiety, HbA1c, blood injection injury

1 Theoretical & Research Basis for treatment

Type 2 Diabetes Mellitus

T2DM is a serious condition where the body has difficulties producing insulin or utilising it properly. This means that individuals with type 2 diabetes have unstable blood glucose levels. Around 90% of people with diabetes in the UK have type 2 Diabetes UK (2020). Diabetes has been considered one of the most behaviourally and psychologically demanding illness (Cochran, 2008). It is serious, progressive condition, which requires lifelong management, as ongoing high blood sugar levels can cause many physical health complications. Treating diabetes by modifying lifestyle and adhering to medication sounds relatively simple, however for many it can cause considerable psychological distress. In type 2 diabetes, dietary changes alone are rarely enough to manage the condition, and medication may be required. While oral medications are used for some individuals with type 2 diabetes, more than 40% of individuals will require insulin, which needs to be injected (Wall, 2021).

Being diagnosed with a long-term condition is understood to coincide with high levels of emotional distress (Johnston, 1998). Statistics also show that the chances of developing depression are almost threefold in people living with diabetes (Fenton, 2006; Simon, 2007; Vamos, 2009). Diabetes distress describes the emotional distress resulting from living with diabetes and the burden of daily self-management. Severe diabetes distress affects one in five people with insulin-treated Type 2 diabetes, and one in six people with non-insulin treated Type 2 diabetes (Diabetes UK, 2020). Individuals can experience a range of negative thoughts and feelings about starting to use injectable insulin. These concerns can be grouped into five main themes as follows: 1) concerns about effectiveness or possible side effects of medications, 2) anxieties about injections or needles, 3) lack of confidence/skills, 4) impact on their life and how they view themselves, and 5) fears about diabetes progression (Mezuk, 2008; Roy, 2012; Moulton, 2015). Concerns about insulin use can often cause individuals to delay the transition from oral medication to insulin (American Psychiatric Association, 2013).

Needle Phobia

Needle anxiety or phobia is not an uncommon issue in medical settings (Marks, 1988). Needle phobia is characterised by a strong psychological reaction to the presence or indeed the anticipation of needles. Needles are routinely used in healthcare settings throughout the world and can present a very real challenge for many individuals. The number of individuals in our population who suffer from needle phobia has been difficult to quantify, given the avoidance of healthcare settings as a result of the condition (Jenkins, 2014). However, globally between 3.5–10% are estimated to have needle phobia (Ayala, 2009). The fear of needles is something that must be addressed as otherwise it can deter individuals from vaccination or assessment and treatment interventions that involve providing venous blood samples or injectable therapies. However, the literature also highlights the phenomenon of treatment resistance in anxiety disorders (Spiegel, 2014), with Leahy (2010) describing an unwillingness to start treatment, premature dropout, failure to comply with exposure and discouragement with progress made as some of the areas of resistance.

Spiegel (2014) described personalising treatment as the best way to address resistance in the treatment of specific phobia, as well as assessing readiness to change at the initial assessment. Both elements help foster a strong therapeutic relationship between client and therapist which for some can be the catalyst in promoting change.

Psychological Interventions

Psychological interventions to manage needle phobia are established in the literature, with successful approaches including exposure therapy, virtual reality therapy, applied muscle tension, cognitive behavioural therapy, psychoanalysis, psychodynamic psychotherapy, Eye Movement Desensitisation Reprocessing (EMDR), hypnotherapy and supportive therapy (Choy, Fyer and Lipsitz, 2007). While Spiegel (2014) found that more recent studies indicated that exposure therapies as the treatment of choice for phobias, she highlighted that the therapy itself may deter many from seeking help. Cognitive behavioural therapy (CBT), has also been reported in many studies as a successful treatment in specific phobias (Kvale, 2004), while hypnosis or hypnotherapy has also been highlighted as a useful adjunct with standard therapies and in particular CBT (Spiegel, 2014).

Cognitive Behaviour Therapy

Cognitive behaviour therapy (CBT), is the usual course of treatment with a patient reporting a phobia, and can be a useful intervention where the phobia is attributable to a learned response (Jenkins, 2014). Vika (2009) reported that successful CBT of specific phobias could be conducted in 8-11 treatment sessions (Kvale, 2004), but that in specific phobias, such as needle phobia similar effects can be achieved in 1-5 sessions of CBT (Ost, 2001). However there is also evidence that hypnosis may also lower injection related distress, particularly in children and adolescents (Uman, 2008), and is often used in conjunction with CBT.

Hypnosis

Hypnosis has been postulated to be the first form of psychotherapy (Spiegel, 2013). Characterised by a state of focused attention with the ability to tune out distraction, with three distinct components; absorption, suggestibility and dissociation, it is a tool which can facilitate individuals to embrace and deal with problems while leaving unhelpful coping strategies to the side.

As described above a phobia is an extreme reaction to a fear. Hypnosis can be used prior to or during a feared situation to enhance an individual's sense of control in the situation, maintain their sense of comfort and put their fears into perspective (Spiegel, 2013). However, as highlighted in Kraft (2016) hypnosis is an adjunctive tool, supporting the treatment of specific phobias, alongside, treatments such as cognitive behavioural therapy and psychodynamic psychotherapy. There is a lack of literature looking at hypnosis as a stand alone therapy in adults, however there are a number of papers which explore its effectiveness with children, which highlight its potential usefulness as an additional tool, particularly in medical settings (Cyna et al., 2007).

A large part of the hypnotherapeutic procedure is to develop rapport with the client. It is helpful if both the therapist and the client develop a strong therapeutic relationship, mutual trust is essential to ensure therapy is successful.

2 Case Introduction

This article describes the treatment of an individual, living with type 2 diabetes and a long-standing history of needle phobia, within the context of a hospital based Clinical Health Psychology department. This secondary care service is part of an acute hospital setting offering psychological input to individuals with long-term physical health

conditions in the following specialities: Oncology; Diabetes; Renal; Respiratory; Chronic Pain; Rheumatology; and Haematology. Individuals living with these long-term conditions can often experience emotional difficulties such as low mood, anxiety, adjustment issues, feelings of isolation, difficulty with symptom management and accepting limitations, and fear. The philosophy of the psychological approach in the health conditions above is acceptance of changes in physical health, acceptance of physical limitations, restoration of function, enhanced self-management of condition rather than the elimination or cure of their condition. The following case presentation describes the assessment, formulation and evaluation conducted by a Trainee Health Psychologist.

3 Presenting Complaints

AB was referred on four separate occasions, once by a [redacted]. On the last occasion, which is the basis of this case study, they were re-referred by a [redacted].

The first referral cited poor treatment adherence to modified diet and oral medication, requiring a move to injectable insulin which highlighted their needle phobia. At this time AB attended for assessment with another psychologist in the department, however declined any further input. The second referral, from a [redacted], again cited significant needle phobia, however, AB contacted the department stating that he had developed strategies to manage his needle phobia and did not require any psychological input. The third referral came from a [redacted], at which time AB attended for assessment and ten further appointments, with the first author, where he engaged well but failed to achieve the goal he had set of addressing needle phobia prior and was discharged.

AB reported symptoms consistent with needle phobia and health anxiety. He had experienced needle phobia from early childhood, with health anxiety becoming a feature in latter years. This anxiety was associated with restlessness, an increased focus on physical symptoms, sleeplessness and chronic fatigue. His symptoms interfered with many aspects of his daily life and he chronically worried about his health deteriorating further. These preoccupations impacted on AB's relationships both at home and socially.

In addition, while AB had been diagnosed with Type 2 Diabetes (T2DM) which was diet controlled, this had changed to the point where he now required insulin. Although AB had endured giving blood samples if necessary, he generally engaged in avoidant behaviours.

His anxiety and avoidant strategies contributed to him comfort eating, which he described as a soothing behaviour. However, he was also aware that it contributed to poor diabetes management and weight gain which was unhelpful for his general health, and this contributed to feelings of guilt and further anxiety.

4 History

AB is [redacted] who grew up in a rural community. His father was employed as a mechanic, and he described his family as middle class. His mother was supportive and warm to AB and his five siblings, however often prioritised his younger brother who had [redacted]. AB did not particularly enjoy school and preferred to spend his time outside working at vehicles with his father.

AB previously worked, initially as a mechanic and in later years as [redacted]. He is happily married, and his wife is employed as a nurse. He describes a loving and supportive relationship with his wife. He is currently a non-smoker having quit smoking 10 years previously.

He described his early years as harmonious, spending lots of time outside with his siblings. However, he recalled a particularly traumatic incident involving a blood draw during an inpatient stay in hospital at age 5. This involved him being admitted to a community hospital, approximately [redacted] from his home for respiratory investigations, once admitted, his parents left to return to their home, and he did not see them until he was discharged approximately one week later. During his inpatient stay a nurse attempted to take a blood sample, however on withdrawing the needle from his arm, it broke, and he described this as being extremely painful. As AB described this event, he became upset and recalled not only his own emotional distress but that of the nurse also, stating that she 'panicked', which further heightened his own distress. He recalled the nurse shouting at him to be quiet and stay still as she was calling for assistance. He remembers crying for his parents and looking out the window, thinking

that he could see their house, but couldn't understand why they wouldn't come to get him. His recollection is that it was quite a lengthy ordeal for the nurse to be able to retrieve the piece of needle from his arm and she required the assistance of other ward staff. He reported a long-standing history of needle phobia since that time. This was manageable until he received a diagnosis of Type 2 diabetes [redacted]. He also reported the death of his brother to cystic fibrosis, when he was 16 years of age, as a difficult event from his childhood.

5 Assessment

A formal assessment taking the format of a 60-minute, semi-structured clinical interview was conducted.

AB presented for re-assessment following a previous 10-session engagement, during which time the goal of attendance was to address needle phobia. While general anxiety was addressed during those sessions, with some relaxation hypnotherapy employed, he remained avoidant of addressing needle phobia.

During this re-assessment he reported increased anxiety with 'down days' but denied any suicidal ideation. He appeared unable to control a shakiness in his right knee and exhibited pressure of speech at times throughout the assessment. He also exhibited a pronounced wheeze on entering the room which appeared to settle as the assessment progressed. He reported that he had developed strategies that allowed him to have regular blood samples; he had identified one nurse in his GP practice who he felt was more adept at blood draws, understood his fears and employed distraction techniques to lessen his anxiety. He also reported that he had strategies that allowed him to administer his insulin; he described a 20-minute mental preparation time, and described using pre-filled insulin pens which he could use to self-inject without having to see the needle. He reported that while these strategies meant that he could maintain both his blood glucose monitoring and self-management of his diabetes, he felt that in the longer term they were unsustainable, and he wanted to address his needle phobia. On further discussion, it appears that he had recently overheard a conversation in his GP practice about his preferred nurse approaching retirement age.

Since his last engagement with health psychology there was a marked deterioration in his respiratory health, and he had new diagnoses of [redacted]

Psychometric Results

The Health Anxiety and Depression Scale (HADS) (Herrmann, 1997) and the Problem Areas In Diabetes Scale (PAID-5) (McGuire et al., 2009) were used to assess anxiety, depression and diabetes distress. AB obtained scores of 17 for anxiety and 14 for depression on the HADS, indicating symptoms of severe anxiety with moderate depression. The PAID-5 generated scores of 12 indicating considerable diabetes distress which was explored further in the context of the clinical interview.

Physiological Results

Greater diabetes distress can be associated with higher HbA1c readings; therefore, the aim of psychological interventions is not only to lessen the diabetes distress an individual is experiencing but to impact of HbA1c readings indirectly. As a result, it was important to record AB's most recent HbA1c reading, so that might be considered alongside post treatment readings. A check of the electronic care record indicated that AB last had a HbA1c reading approximately 5 weeks prior to the assessment which was 79mmol/l (NICE Guidelines recommend a target HbA1c level of 53 mmol/mol for adults with T2D (NICE, 2015)).

6 Case Conceptualization

In formulating AB's needle phobia, it was clear that his early experience of needles at 5 years of age had a significant impact on his ability to trust healthcare professionals or to see needles as anything but negative. This was considered a predisposing factor and combined with the experience of losing a sibling to a life limiting condition which had required regular medical intervention, potentially meant that AB did not have a positive experience of healthcare services. However, he later married a nurse, which could be viewed as a protective factor, allowing his experience of healthcare professionals to be more balanced overall. He reported a considerable degree of medical involvement since his diagnosis of type 2 diabetes [redacted]3 and noted that for the most part the healthcare staff that he had encountered had been understanding and professional, another protective factor. In terms of a precipitating factor, currently his medical interventions had increased, he continued to require regular blood samples to monitor his HbA1c for his diabetes but also now required to have blood gases taken on a regular basis.

AB was seen to have had a traumatic experience with healthcare, and in particular needles, at an early age, however had coped with this using avoidance strategies until recent years when his health had deteriorated. This acted as a precipitating factor which triggered his earlier memories and presented as needle phobia, which is perpetuated by the need for regular blood glucose monitoring and insulin administration. While he had developed ways of managing his needle phobia, these were no longer as effective as they had been. With the increasing need for regular medical input AB now recognised that alternative strategies were required. Previous attendance at health psychology was also considered something of a protective factor. While the previous sessions had failed to address the needle phobia, the therapeutic relationship was seen to be positive, therefore creating a safe space where AB now felt more comfortable addressing difficult issues. Exploring the evidence identified that hypnosis had the potential to lower injection-related distress, particularly in children and adolescents (Uman, 2008), and based on the fact that his negative response to needles developed from an early childhood experience it was felt that this was a potentially useful approach for AB. Also, the knowledge that we had previously employed a relaxation hypnotherapy script to good effect led us to believe that this was an acceptable treatment for the patient.

7 Course of Treatment and Assessment of Progress

At the assessment AB stated that his goal was to be less fearful of needles, and less anxious of medical interventions generally. The formulation developed above was shared with him on the first session and while he identified with it, he was also shocked to realise that avoidance strategies had been such a prominent coping strategy for him. Using this formulation, alongside the knowledge that a therapeutic relationship already existed based on his previous attendance at health psychology, it was felt that reducing his fear of needles could be addressed in a small number of sessions.

As highlighted previously Cognitive behaviour therapy (CBT) is the usual course of treatment with a patient reporting a phobia, and can be a useful intervention where the phobia is attributable to a learned response (Jenkins, 2014). In this instance, the needle phobia was not attributable to a learned response, it was a response to a traumatic event. AB had himself, unknowingly but through necessity, already engaged in exposure therapy and had achieved some success with this however felt he had achieved all he

could using this strategy. Having presented the formulation and evidence with AB, as well as his previous avoidance of addressing this issue, we agreed that the focus for treatment would be hypnotherapy to address needle phobia over approximately six sessions at fortnightly intervals, with review thereafter.

From a previous occasion where we had employed hypnotherapy for needle phobia, we did not feel we would require all six sessions. However, having also worked with AB previously during his third referral to the service, we were aware that he did not like to feel under pressure. It was felt that six sessions allowed us to set a focus for our contact without putting him under undue pressure. The first author informed AB that the hypnotherapy could produce positive results quickly but that equally it could take a few sessions to see an effect.

Session 1

Sharing of the formulation as highlighted above, clarification of the initial fearful event, and exploration of any concerns regarding hypnotherapy, were all considered during this session. Time was also spent exploring what AB's expectations/goals for treatment were. He explained that while he had developed strategies to manage his needle phobia, he still experienced significant anticipatory anxiety which 1. meant that taking his insulin could take from 10-20 minutes each time and 2. meant that he would only have blood draws if his preferred nurse was on duty and he was accompanied by his wife to the appointment. He stated that he was keen to be able to administer his insulin without it taking so long and would love to attend on his own for blood draws with nurses other than the one he was used to. He stated that he did not envisage ever being particularly comfortable with the thought of a "sharp implement stabbing" him however felt that if he could become more comfortable with administering his insulin and attending for blood tests, he would be happy with this outcome. It was agreed that these were reasonable expectations of treatment and that we would begin by trialling a specific needle phobia at his next session. We requested that he start to use the previous relaxation hypnotherapy, which had been recorded to CD for home practice, daily ahead of his next appointment as we would incorporate this into the needle phobia script.

Session 2

Having identified a needle phobia script (see appendix 1) that had been used successfully with other patients in the past, we felt that it would be useful again in this scenario. The first author spent the first 15 minutes of the next session introducing AB to how we would proceed, what he might expect and introducing some aspects of the script to garner his thoughts on prior to beginning (rehearsal). The script involved the concept of running through the events of the situation where the phobia began as if seeing them in a film. So, in advance of the beginning the script we spent some time exploring AB's earliest recollections of attending a cinema. He reported remembering attending a small local cinema as a teenager. He was able to describe the experience in detail and focused particularly on the visual image of how the curtains slid open at the beginning of the film and closed at the end. His clear and detailed recollection was encouraging, it reinforced that the script chosen was one he would identify with and was therefore appropriate. When AB was familiarised with the plan for the session and was comfortable to proceed, we began by using the initial relaxation script that he was already familiar with as the induction and followed this with the needle phobia focused script and termination. The script allowed AB to confront his fear in a safe and comfortable environment, therefore experiencing it as a non-threatening experience; it also aimed to increase his self-confidence when exposed to needles and made use of positive post-hypnotic suggestion regarding his fear of needles so that future responses would be positive (Hadley, 1997).

AB was familiar with both the therapist and the concept of hypnotherapy, having been introduced to both during his previous attendance at health psychology. This allowed him to feel comfortable and relaxed from the outset, as he had a previous positive experience. A therapeutic alliance already existed and was developed further through the process of assessment and during his first appointment. Having set the scene, and encouraged him to adopt a comfortable seated position and proceeded with the relaxation script as the induction, the therapist was aware quite quickly of a change in the rhythm of his breathing suggesting that he was starting to become more relaxed, on observation he had become quite pale and slack jawed which confirmed that the body was very visibly relaxing. The script also involved using an ideomotor response, in this case a nod of the head to confirm that AB had completed a particular task in his subconscious mind. This is something that he engaged with readily, and although the

nod of his head was slight, it was definite and did not require any additional prompting. As the script proceeded, AB appeared visibly comfortable and relaxed and as we entered the termination phase, he started to regain colour in his face while his breathing and some slight movement behind his eyelids and in his feet. He was instructed him to take a few moments longer with his eyes closed and then slowly reorient himself back in the room. As he did so there was an audible sigh/yawn which was coupled with an exaggerated stretch, like that of someone who was waking from a good night's sleep.

His initial statement was "that was so good". He reported feeling an overwhelming sense of relaxation and appeared still somewhat dazed for the first few minutes. When he became a little more focused, he reported that he felt being able to watch the scenario where his fear of needles began, as if it was a film. He also reported that it had helped him recall additional details that he had forgotten previously – he recalled looking out the window when the staff were trying to extract the broken needle from his arm, and how he could see houses in the distance which he thought were similar to his own house, and how he couldn't understand why his parents didn't come to see him. As an adult exploring this now, he was able to rationalise what had happened however this was an important element of that early experience that he had been unable to recall previously. One aspect of the script required AB to identify a place that was special to him and to nod once this was complete. When asked if he had been able to do this with ease, he reported that he had enjoyed this aspect of the script and reported that the place was called "[redacted]", and was associated with many happy memories for him. He told me that he was keen to take his next insulin injection that evening to assess if the script had been successful and while it was felt that this was a natural response, he was reminded that we had discussed previously how it could potentially have an impact after one session but may require more than that. We did not want him to perceive any lack of change in his needle phobia as a failure of the treatment at this early stage. We also discussed the possibility of tailoring the script to him specifically, since he had responded well to it as we felt this would help him further engage with it.

Session 3

At the beginning of this session AB reported that he felt the last session had a positive impact. He reported feeling more at ease with the thought of taking his insulin injection. He described again how, prior to our last session, it took him between 10-20 minutes to

take his injection, however he also described how this was after approximately 45 minutes of knowing he needed to take it soon and "working himself up" to get everything ready. He reported that it was only after our last session that he recognised this other element of preparation, when his wife pointed out that he got everything ready immediately after he stated he needed to take his injection. He was excited to relay this information and keen to practise the script again. He explained that he felt less anxious taking his insulin but would like to see if he could reduce this further and shorten the time to take his injection.

We advised him that we had spent some time tailoring the script to his situation and asked if he would mind if we audio-recorded the hypnotherapy session so that he could use it at home following the session. He consented to the audio-recording stating how he found it beneficial on his previous attendance. In tailoring the script, his name was used throughout, changing some of the vocabulary to make it more similar to his own vernacular and, where possible, we included references to what we had previously discussed in relation to his particular presentation. While these changes appear quite subtle, they were important and would further aid his engagement with the script. He was happy to use the tailored script and we proceeded slowly. we felt that his excitement had left him energised and were keen to foster a strong relaxation to give the script the best possible opportunity to work, therefore felt that really slowing things down was important. As before, on observation, AB relaxed well, although it possibly took a little longer than on the previous occasion. We proceeded through the script as we had previously and again spent some time discussing his experience before we ended the session. On this occasion, AB reported that the use of his name throughout the script really made it very personal to him; he also picked up on the mention of driving a bus as this was his last paid job before he was medically retired, so again really helping him identify closely with the script. We had audio recorded the session and we agreed to transfer this to CD and post it to him so that he could continue practising the script at home and he reported being grateful for this. Before he left, we agreed that we would take some time at our next session to review progress overall and re-evaluate.

Session 4

Prior to this session, we received a telephone call from a practice nurse in the local GP practice. She introduced herself as the nurse who has been doing AB's regular blood

draws for the past 6 years and wanted to know what 'the trick' was to curing needle phobia. She told me that AB had been in for a routine blood tests and that it had been the quickest she had ever been able to get a blood sample from him. She reported that he had attended with his wife as usual but was he most relaxed she had ever seen him. This made me excited for this next session with AB.

AB attended this appointment with his wife. They were both in high spirits as they entered the office, with AB's wife stating that she would only stay for a short time. They started by recounting their most recent attendance at the GP's practice for his regular blood draw. AB reported that he felt his most recent experience of giving a blood sample was completely different to any previously. He stated that although he still wanted his wife with him, he was much less anxious both prior to and during the blood draw. He described not being keen to see the needle, however, he did not experience the same level of anxiety as he had done previously, and he felt that this had speeded up the procedure. AB's wife reported that she had observed a significant difference in his attendance for the blood draw but also in his ability to take his insulin daily. She excused herself and left to return to her work, leaving AB for the remainder of his session. We reminded him that we had planned to review his progress during this session and potentially re-formulate the intervention. AB stated that he felt the hypnotherapy for needle phobia had been successful, and mentioned his recent positive experience having blood taken and reported that on the whole his insulin injections were requiring less and less time and that his anxiety level had decreased. We agreed that he certainly seemed excited about the changes he had noticed and asked if he would mind completing the HADS and PAID 5 again so that we could evaluate these against his baseline scores. His HADs scores had reduced for both anxiety (13) and depression (11), while scores obtained on the PAID-5 (9) had also reduced but to a lesser degree. HbA1C readings were not available at the time of appointment however AB gave consent for to follow these up in his electronic care record within the week. Asked if he had received the CD of his recorded sessions with the tailored hypnotherapy script, he advised that he listened to it every second day. He said that he felt he could now sit down and think about it and feel a sense of relaxation wash over him immediately, a strategy that he had employed at his recent appointment with the practice nurse. AB felt that he did not require any further intervention at this stage as he had achieved the goals outlined at

the beginning of treatment. We discussed potential discharge, however, opted for 2 further appointments as we had initially planned, one after a month and a second appointment in 3 months' to follow up on progress.

8 Complicating Factors

The follow-up in this case occurred just after face-to-face appointments in the NHS were suspended as a result of COVID 19. As such, AB's care changed to telephone contact and this could be a complicating factor.

9 Access and Barriers to Care

There were no barriers to care in this case.

10 Follow-Up

A follow-up session was conducted a month later via telephone as a result of restrictions on face-to-face appointments at that time. Both AB and his wife were present and reported continued satisfaction with the needle phobia treatment. AB reported that he wished he had been able to engage with it during our earlier contact as it had made such a significant impact on how he now managed his diabetes. He explained that his daily blood sugar readings were more consistent, and he felt this was a direct result of being less fearful of his injections, which meant that he no longer delayed taking his insulin. He described how he had previously needed some time to build up to taking his insulin; this was then followed by approximately 10-20 minutes to administer it, during which time he would be extremely anxious. He now did not feel the need to take that time building up to taking his insulin and reported that he had administered his insulin during the earlier part of this call, something which he stated he never felt he would be able to do.

HbA1C results from his previous appointment illustrated a small reduction at 1-month follow up (68mmol/L), however a more significant change in HbA1c reading was noted at 3-month follow up (57mmol/L) and is illustrative of improved adherence and self-management, supporting his self-report. Scores obtained on the HADS (Anxiety-12, Depression-11) and PAID-5 (10) at 3-month follow up remained stable, supporting AB's account of maintaining the progress gained during the first few treatment sessions.

11 Treatment Implications of the Case

This study indicates support for the use of a brief, tailored intervention for needle phobia in an adult with type 2 diabetes. The initial case formulation had allowed 6 sessions for intervention delivery, however, in essence the bulk of the treatment was delivered in 3 sessions, with the initial meeting being a psycho-education session, and the following covering delivery of the hypnotherapy scripts. This brief, tailored intervention was effective in this instance, according to self-report and in terms of reduction in HbA1c and questionnaire measures, however it should be noted that previous engagement with the same psychologist may have been a factor in facilitating the small number of sessions required on this occasion. Given that there was a prior therapeutic relationship established, trust already existed between psychologist and patient and had a potentially positive impact on this further contact. This intervention also tailored the pre-existing needle phobia script, to include personalisation and the insertion of keywords which also potentially allowed greater engagement with the script, as had been highlighted in Spiegel (2014). AB was encouraged to continue practice of the script outside of session and this is something that he reports doing regularly and has continued to do at 3-month follow up. This is also a factor in consolidating the work done in session and cannot be ignored. As highlighted in Elkins (2014, p.91) continued use of hypnotherapy scripts following sessions can be used to enhance coping skills through reinforcing positive self-talk and maintain the goals achieved in therapy and thus prevent relapse.

12 Recommendations to Clinicians and Students

There are several recommendations that this case suggests to clinicians and students. This case suggests that the pace of the intervention is important; AB had been referred on a few occasions previously to address needle phobia. He had previously attended 10 appointments and was extremely avoidant of addressing it at that time. This was a source of frustration for the psychologist, however a clinical judgement was made that it was more important to develop a sound therapeutic relationship, and develop a positive association with a healthcare worker at that time than encourage him to confront his needle phobia. While this meant that he was discharged and re-referred later, it appears that this pace suited this individual. This is supported by the literature which suggests that the “hypnotic induction begins at the door” (Hadley, 1997, p.275).

In this instance the hypnotic induction began at the door at our previous contact. AB had been referred to our service on four separate occasions. He attended for assessment with my colleague on his first referral, did not attend on his second referral and met the first author on both his third and final referrals. His familiarity with both the service and, in latter referrals the same psychologist might have facilitated successful outcomes in this case. It is also important to consider the possibility that while this was a case where hypnotherapy was used on its own, the previous treatment, which was CBT focused could be considered the main therapy with hypnotherapy as the adjunct, as previously discussed in other studies (Frankel, 2010; Watkins, 2013; Spiegel, 2014; Slatter, 2016).

It also highlights the importance of a full and thorough assessment and taking the time initially to get to know the individual you are working with. Small details can be 'nuggets of gold' that once inserted into a hypnotherapy script help engage the individual. For this individual their previous engagement with the psychologist, laid the foundation for this brief intervention to be built upon.

The literature on the use of hypnotherapy to address needle phobia is focused on child and adolescent cases. However, this case illustrates that it can indeed be effective with adults if paced properly and tailored to the individual. It can offer significant satisfaction to the patient while also impacting positively on emotional and physiological measures. Improved self-management often translates to positive effects on patients' lifestyle and health outcomes, which further motivates them to maintain self-management, which ultimately limits condition related complications and associated healthcare costs.

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Appendix 1 – Original Needle Phobia Script

Fear of Needles (Original)

In the past you were worried about the thought of needles and/or administering injections into other people's skin - in fact the very thought of it could make your knees feel like jelly and you just wanted to escape from the situation.

Most people who are not afraid of needles do not enjoy getting shots but find it mildly uncomfortable. You can seek medical attention comfortably. Wouldn't it be better to make your medical decisions with a calm mind?

These days even the discomfort is minimal thanks to special topical anaesthetic preparations which can numb the nerves before needle procedures - therefore the only situation that you really need to deal with is the fear - which in humans and animals alike is something that has been learned - usually from a past unpleasant experience.

And if you can learn fear - then you can unlearn it - and you - more than many other people - can be successful in doing this - because your past experience caused you to be negatively hypnotized. And anyone who has been negatively hypnotized can also be positively hypnotized - because you already have a wonderful imagination - otherwise that wouldn't have happened to you.

So, I want you to use your creative imagination right now - and go back to a time when you were scared of having a needle inserted into your skin - (or administering a needle into someone else's). It could be a recent event or something from long ago - it really doesn't matter - because what I'd like you to do is imagine that scenario on a film and watch as though it's happening to someone else.

Do this now and I'll be quiet for a moment - and when you get to the end of the film, I want you to pause it and nod your head.

(Wait for signal)

That's good. Now I'd like you to run through that film again - but this time I want you to run it backwards - from where you paused to before the beginning of the actual event. So - run it backwards in your mind now and let me know when you've done this.

(Wait for signal again)

Okay - now jump forward until you're back where you originally paused the film - and run through it backwards again in your mind - and as you do so - notice how you lose all those negative feelings that were associated with needles - and you're feeling calm and relaxed and confident again.

If there are any other memories associated with needles, then run backwards through them - as well. Reverse the uncomfortable feelings - deprogram yourself from that old fear of yours - you don't need it - you don't want it - you'd much rather be in control - and you are.

And as you do this - an amazing thing begins to happen - you begin to feel so much more confident about the thought of needles - so much so - that you're going to learn a new technique which will help you the next time you are in a situation where needles are present.

I wonder if you've ever experienced yourself traveling along on a familiar journey - perhaps driving your car or traveling on a bus or a train - and during the journey you find that your mind begins to wander and it's almost as though you are somewhere else - but if you're driving - you stop when the lights turn red and start again when they're green - or if you're a passenger you suddenly realize that you've reached your destination and your daydream ends?

What has happened is that you have gone into autopilot - you can still function perfectly - but your mind has taken you somewhere else. In hypnosis this is termed 'dissociation' - and can happen spontaneously or at the command of a post-hypnotic suggestion. So we are going to use this technique whenever you find yourself in the presence of needles - and if you're administering an injection you'll find that you can perform even more effectively than ever before - if you're receiving an injection or giving blood or doing anything else to do with needles - you will feel as though it's happening to someone else - and your subconscious mind can take you on a very special journey of discovery.

Imagine yourself now in the place where you'd most like to be. This can be somewhere out in nature - a peaceful, tropical beach - or out in the country - you could be sailing down a river or

curled up in bed or perhaps lying in the arms of the person you love. It really doesn't matter where it is - as long as it's a place that is special to you.

Nod you're head when you're there in your mind.

(Wait for signal)

Good - and I want you to give this experience a title that your inner mind will recognize and take you to at will. Let me know when you've thought of a relevant title.

(Wait for signal)

Good, and this title is now your key word for post-hypnotic response.

Now make this place brighter and happier - add feeling and colour and depth - make it as good as it can possibly be - and when it is - take a couple of deep, refreshing breaths - whilst your subconscious mind memorizes this wonderful experience.

(Wait for subject to take two, deep breaths)

And in the future - whenever you are in the presence of needles of any kind - all you need to do is to think of your key word and take those two, deep refreshing breaths - and your subconscious mind will automatically transport you through time and space - to your special place - and you'll feel so good, so happy and so confident here that whatever is going on around you, doesn't bother you - it's just as though you are here again.

And the amazing thing is that you'll be able to do or to perform whatever you need to - and you'll feel so proud of yourself - and you deserve to be proud of yourself because you are now unleashing the power of your wonderful subconscious mind.

And these suggestions are firmly embedded in your subconscious mind and grow stronger and stronger day by day. Stronger by the day, stronger by the hour - stronger by the minute.

In a moment I'm going to count from one to five and at the count of five you will be wide awake, fully alert and refreshed. You will have wonderful feelings flowing through your body - calm and peaceful thoughts flowing through your mind. And these calm and peaceful thoughts and feelings are going to remain and stay with you.

One - two - three - coming slowly back - four - eyelids beginning to flicker and five - eyes open - wide awake, refreshed and relaxed - mind and body returning to normality.

Appendix 2 – Tailored Needle Phobia Script

Fear of Needles

OK AB, in the past you were worried about the thought of needles and/or administering injections into other people's skin, the very thought of it could make your knees feel like jelly and you just wanted to run from the situation.

Most people who are not afraid of needles don’t enjoy getting shots but just find it uncomfortable. You can seek medical attention comfortably. Wouldn't it be better to make your medical decisions with a calm mind?

These days even the discomfort is minimal thanks to special topical anaesthetic preparations which can numb the nerves before needle procedures - therefore the only situation that you really need to deal with is the fear - which is something that has been learned - usually from a past unpleasant experience.

And if you can learn fear - then you can unlearn it - and you - more than many other people - can be successful in doing this - because your past experience caused you to be negatively hypnotized. And if you have been negatively hypnotized can also be positively hypnotized - because you already have a wonderful imagination - otherwise that wouldn't have happened to you.

So AB, I want you to use your creative imagination right now - and go back to a time when you were scared of having a needle inserted into your skin. It could be a recent event or something from long ago - it really doesn't matter - because what I'd like you to do is imagine, walking into an old style cinema, where the curtains are drawn back at the beginning of the film and close as it ends. Once you’ve gone in and found the right seat I want you to imagine that scenario on a film and watch as though it's happening to someone else.

Do this now and I'll be quiet for a moment - and when you get to the end of the film I want you to pause it and nod your head.

(Wait for signal)

That's good. Now I'd like you to run through that film again - but this time I want you to run it backwards - from where you paused to before the beginning of the actual event. So – run it backwards in your mind now and let me know when you've done this.

(Wait for signal again)

Okay - now jump forward until you're back where you originally paused the film - and run through it backwards again in your mind - and as you do so - notice how you lose all those negative feelings that were associated with needles - and you're feeling calm and relaxed and confident again.

If there are any other memories associated with needles, then run backwards through them - as well. Reverse the uncomfortable feelings - deprogram yourself from that old fear of yours - you don't need it - you don't want it - you'd much rather be in control - and you are.

And as you do this AB- an amazing thing begins to happen - you begin to feel so much more confident about the thought of needles - so much so - that you're going to learn a new technique which will help you the next time you are in a situation where needles are present.

I wonder if you've ever experienced yourself traveling along on a familiar journey - perhaps when you've been driving the bus - and during the journey you find that your mind begins to wander and it's almost as though you are somewhere else - but if you're driving - you stop when the lights turn red and start again when they're green?

What has happened is that you have gone into autopilot - you can still function perfectly - but your mind has taken you somewhere else. In hypnosis this is termed 'dissociation' - and can happen spontaneously or at the command of a post-hypnotic suggestion. So we are going to use this technique whenever you find yourself in the presence of needles - and when you're administering an injection you'll find that you can perform even more effectively than ever before - if you're receiving an injection or giving blood or doing anything else to do with needles - you will feel as though it's happening to someone else - and your subconscious mind can take you on a very special journey of discovery.

Imagine yourself now in the place where you'd most like to be. This can be somewhere out in nature - a peaceful, tropical beach - or out in the country - you could be sailing down a river or curled up in bed or perhaps lying in the arms of the person you love. It really doesn't matter where it is - as long as it's a place that is special to you.

Nod you're head when you're there in your mind.

(Wait for signal)

Good AB - now I want you to give this experience a title that your inner mind will recognize and take you to at will. Let me know when you've thought of a good title.

(Wait for signal)

Good, and this title is now your key word for post-hypnotic response.

Now make this place brighter and happier - add feeling and colour and depth - make it as good as it can possibly be - and when it is - take a couple of deep, refreshing breaths - whilst your subconscious mind memorizes this wonderful experience.

(Wait for subject to take two, deep breaths)

And in the future AB - whenever you are in the presence of needles - all you need to do is to think of your key word and take those two, deep refreshing breaths - and your subconscious mind will automatically transport you through time and space - to your special place - and you'll feel so good, so happy and so confident here that whatever is going on around you, doesn't bother you - it's just as though you are here again.

And the amazing thing is that you'll be able to do or to perform whatever you need to - and you'll feel so proud of yourself - and you deserve to be proud of yourself because you are now unleashing the power of your wonderful subconscious mind.

And these suggestions will grow stronger and stronger day by day. Stronger by the day, stronger by the hour - stronger by the minute.

In a moment I'm going to count from one to five and at the count of five you will be wide awake, fully alert and refreshed. You will have wonderful feelings flowing through your body - calm and peaceful thoughts flowing through your mind. And these calm and peaceful thoughts and feelings are going to remain and stay with you.

One - two - three - coming slowly back - four - eyelids beginning to flicker and five - eyes open AB - wide awake, refreshed and relaxed - mind and body returning to normality.

Research Commentary

As I approach the end of the course, and finish up my research competency, I am struck by how much my plan of training has changed. While I am acutely aware of the importance of research in terms of informing evidenced-based practice, I have to admit that I am not overly comfortable conducting research. However, having conducted a piece of research at MSc level fairly recently I had a research question in mind that I felt would cover all three aspects (empirical paper 1 & 2, and systematic review) of the research competency as I embarked on this phase of study. My initial plan was also that the research competency would be addressed early, however, the reality was somewhat different!

The Plan of Training was useful in focusing my thinking and developing a roadmap for the two years to follow. It was designed to offer structure while allowing for flexibility, however, I had not anticipated requiring just as much flexibility as I did. Initially, planned to develop my plan of training and get my research underway within the first semester, allowing time to apply for ethics and potentially data collection towards the end of the first year. I neglected to consider the physical demands of travel to and from university, how this impacted on both home and work life and as a result feel that the first few months were an adjustment period. I had the opportunity within these first few months to discuss my research idea with my supervisor at work and start to refine it, but it felt as if everything was taking much longer than it should. Just as I felt I was beginning to build up some momentum I experienced a setback. In mid-March 2019, our team secretary lost her [redacted] son [redacted]. Some might argue that, while this was a very sad event, it shouldn't have impacted me directly, however it had a major impact on me both personally and professionally. My plan had been to address research early on to ensure I was not held up with a lengthy ethics proposal, and I also wanted to 'get it out of the way' – face my fear early and then move through the rest of the competencies, which I felt more comfortable with. While I may not have been fully aware of it at the time, I felt very vulnerable following his death and while I had been ready to embrace change and the things that made me uncomfortable, this changed and I did only what was needed at the time. So, despite some discussions about my research

with my supervisor early in 2019, my ethics application was not submitted until March 2020, just prior to the COVID-19 restrictions coming into effect. Revisiting ethics training was an important and essential aspect, as were discussions with the Research and Audit department of my healthcare trust and engaging with the Health Research Authority, even if they were sometimes repetitive and not exactly clear. However, as my research involved healthcare staff, it was important to ensure that all guidelines regarding the involvement of healthcare staff in research were fully explored and adhered to.

My ethics application to the proportionate review University Research Ethics Committee (UREC), allowed me to focus my thinking around the research question and fully consider all the relevant aspects. While I was certain that the potential risk of harm to my participants was minimal, completing both the ethics training and the application form made me explore this further. My ethics application was submitted in mid-March 2020, a day ahead of the governmental directive to social distance as a result of COVID-19. I had initially proposed utilising focus groups to explore the experience of the diabetes team in using health behaviour change techniques. This required revision as a result of social distancing, therefore I adapted the protocol and opted for one-to-one interviews, conducted via a virtual platform. A revised ethics application was submitted quite quickly and approved in April 2020. This sounds quite clinical and straight-forward, however, it didn't feel like that at the time. I recall feeling frustrated and annoyed; just as I was ready to get started with this, COVID came along and derailed everything. In that first week, work was crazy as we all tried to adapt to the uncertainty of our current clinical practices, I was also contemplating rethinking my research, and that frightened me. While I know that I can conduct sound pieces of research, it is not the most natural area of work for me. I am comfortable researching issues related to clinical practice, and for me these areas tend to present themselves as areas of research rather than me sitting down and identifying an area I'd like to explore further. So being in the position where I might need to identify another area of research left me feeling extremely vulnerable and envisioning the possibility that I might need to take a lengthy extension. When I think back to completing my Plan of Training in early 2019, I remember being mindful that not everything would go to the schedule I was proposing. I intended it to be flexible and I knew that there would be key time points where my children had transition periods in their school life and tried to factor this in. I had a plan but had

allowed for some 'wiggle' room in case things didn't go just as I hoped. At this juncture, as I reflect on my research and the doctorate, I don't think I could have envisioned the roadblocks that I encountered along the way. Having received the ethics approval I was keen to proceed with the research and make a start in achieving this competency, however, my research didn't get underway until early September 2020.

I was keen to get my research underway, but was also aware that we were fast approaching the summer holiday period, when staff would be taking annual leave. Despite this I initiated the recruitment phase, however had little response initially. I discussed this with my supervisor and service lead of the diabetes team, and they advised waiting until late August. While there was more interest at that time, I was still disappointed in recruitment rates. I had been optimistic that approximately two thirds of the participants from my previous MSc study would take part, unfortunately this wasn't the case. The previous study was carried out in 2017 and I had anticipated natural movement of some staff, however, was also aware that many of the previous participants were still part of the diabetes team, so was disappointed at the low rate of uptake.

However, having volunteered on the COVID-19 staff helpline throughout the year I was aware of the stress that many of my colleagues were under, as a result of the pandemic. Greater demands had been put on all staff within the Trust, with expectations of doing things differently, and many being redeployed or taking on additional duties to assist those most in need. My research had the full support of clinical leads, it involved, for the most part, staff conducting either community or outpatient clinics, therefore could be argued that they were not as directly affected by the pandemic as those working on COVID wards. However, regardless of department or clinical role, all staff have been impacted, both personally and professionally. I believe that this had an impact on recruitment rates, as staff were tired, frustrated and possibly unable to contemplate fitting something else into their normal working routine. Participation in my research was voluntary, and in their eyes, possibly not clinically important, therefore, they could opt out of it with no repercussions, which is what I feel may have happened for some.

During data collection one participant highlighted the emotional impact that being unable to implement health behaviour change had on her and some of her colleagues. She described how they felt the weight of expectation far outweighed the reality of what they could provide and the reluctance this created to discuss any aspect of health behaviour change. This is also something that I feel may have impacted on my recruitment rates. I thoroughly enjoyed the data collection, even though the participants involved reported not fully implementing health behaviour change skills, it was clear that there was a hunger to do so. This reinforced the rationale for this piece and allowed me to see that for these participants at least this was a clinically relevant piece of work. I also think that, with any research I'm involved with, the data collection element is where I'm most comfortable. For me, this is the part that really brings the research question into clear focus, looking at the raw data and analysing it is key to answering the research question, but being involved at the data collection stage 'grounds' me as to why the research question was important in the first instance.

As I moved to the analysis stage, I needed to do some training. I had planned on using NVivo for my analysis, however, was not familiar with the package, and while I had been dreading having something new to learn, I thoroughly enjoyed getting to grips with NVivo. It certainly made the analysis much more streamlined and contained, and while helping me identify the themes within my data, it also helped me present these in unique ways (word clouds) which have helped when disseminating the data with the diabetes team.

I prepared my final report for submission to the *British Journal of Health Psychology*. I could have chosen a number of other journals, perhaps with a greater focus on diabetes or nursing, however, I feel that despite being focused on the diabetes teams and the implementation of health behaviour change skills with staff, my research question actually has wider scope. At this stage of my training, I feel that I have become much more confident within myself but also with my level of knowledge in the area of health psychology. While I work within a health psychology department of a local hospital, it is run and predominantly staffed by clinical and counselling psychologists. There is a particular awareness among the staff of the clinical issues that individuals face daily, however there is possibly less awareness or focus on the underlying health psychology

theories and models. When I think back to my MSc study, which was guided by one of my clinical psychology colleagues, I am frustrated. I was very accepting of the advice offered by [redacted]. As I completed this piece of research I realise that there was very little in the way of health psychology theory underlying the development of that health behaviour change skills training. So, while I feel that this piece of research has relevance to diabetes staff and AHPs, I feel it may have greater relevance in the area of health psychology. A psychologist be they clinical, counselling or health trained will look towards psychological publications in developing health behaviour change training within their own teams, therefore publishing my research in a psychology focused journal could have greater clinical impact in the long term.

I started my systematic review on several occasions. Initially intending to complete it ahead of submitting my application for ethical approval. I felt this would allow me to address one arm of my research competencies while informing my research proposal and ethics application at the same time. In reality what happened was that I completed a literature review in early 2020 and assured myself that I would complete the full systematic review ahead of data collection for my first piece of research, which didn't happen, again I started it, hit a stumbling block and moved on to a different piece of work instead. With this degree of procrastination and my comment about enjoying the data collection element of research above, you can see that I wasn't overly enthusiastic to start my systematic review. I think that while the systematic review was not something that I relished; I was simply lacking in time. My systematic review was completed in the early part of 2021, and while I think that my self-imposed deadline to complete the course by 31st March 2021 certainly focused me, I also think that having quite a lot of annual leave to use before that deadline also helped. For me, a systematic review requires a steady focus over a single period of time, while a case study or a consultancy report for example can be completed in a number of stages over weeks or months. Having every second Thursday free of clinical cases to study for my doctorate was so useful, and of course there were many more hours in the evenings and weekends where elements of work were completed. However, I did not feel that proceeding in that way on a systematic review worked for me, no matter how many notes I took, how much I recorded, I felt that it was very difficult to pick up where I had left off. Having a few weeks, with a clear focus on research only, allowed me to address the systematic

review in a consistent manner which worked for me, and while it was intense and didn't leave much time for family or anything else, I'm not sure I could have completed it otherwise. As I progress into a qualified post, I think this is something that I need to be mindful of in future research. While there are elements of research that I know I can do over time, there are also elements that for me are better done within a dedicated time frame. While this may seem like a lot of time to allocate to one thing, in reality managing my time in this way is likely more efficient in the long run, as I have found out in this work.

At this stage, I realise that I've dedicated most of this commentary to my first empirical paper and the processes around that, and in many ways that reflects exactly how I engaged with the research competency in this course. It's not how I would advise anyone else to do it, and it's certainly not how I had planned to do it myself, but here we are. While, this approach was not ideal, it worked, to a degree, in this instance. I struggled to manage the demands of a busy clinic alongside conducting research and having a block of time to dedicate to sustained activity on the research competency was really helped. The downside of this however, is that it has been exhausting and family life has taken a back seat during this time, which isn't ideal. Going back to my plan of training, I had initially planned a piece of research that would give me both qualitative and quantitative results, allowing for two distinct pieces of research (empirical papers 1 and 2). As I developed my research question further and applied for ethics approval, I neglected to consider the fact that my research question now only gave me qualitative data and therefore one paper. As I completed empirical paper 1 and realised that I now had my systematic review and empirical paper 2 outstanding the panic kicked in; I had a huge amount of work to complete in just conducting my systematic review and analysing data for a second research question, however there was no data for the second research question, and in my case little time remaining to develop another research question, apply for ethics, and collect and analyse data!! This is where waiting to conduct the research competency in one dedicated portion of time became problematic but thank goodness for calm and collected supervisors. After scheduling a meeting with my supervisor via video link, I considered my options for a second empirical paper. Starting from scratch with a second research question was an option that would see me far beyond the deadline I had set to complete the portfolio, so wasn't

an option I was keen to embrace. I thought about my areas of strength and felt my clinical work possibly presented an area of rich data and I wondered if a case study might work; it seemed the most achievable option at the time. In supervision, again it was one of three options discussed and eventually the one I ran with and really enjoyed writing up. This is something which makes me think more about my earlier statement about not being particularly comfortable conducting research. On reflection, that statement isn't entirely accurate. I did not enjoy the systematic review and found it 'dry', I did however enjoy both empirical papers 1 and 2, and feel this was due to the fact that they were tangible, they involved participants that I could relate to, therefore the data was more meaningful in my eyes. Throughout the doctorate, something that has become apparent to me is how important it is to challenge myself but also to work to be true to myself. I find that when I work this way, instead of trying to fit into an idea of what a trainee health psychologist 'should' be, I am more comfortable, those around me are more comfortable and the work becomes easier and feels much more natural. This leaves me more energised and I think I then focus easier and apply myself to it sooner that I did with the systematic review, which didn't excite me at all.

As I've already said, research has not always been an area I've felt particularly comfortable in and this commentary reflects that. However, this commentary also reflects a development in me as an individual and as a professional, which ultimately has an impact on my research skills too. Looking back, time management in respect to this research competency was poor, due in part to my procrastination, but also to the real struggle of combining work, study (with travel) and home life. While I would have preferred to have started the research earlier, the commitment of attending class during that first year was more taxing than I had anticipated, and I pushed research further down the agenda as a result. There were other factors at work too, which emotionally had a significant impact and meant that I stayed with 'safe' pieces of work, those that I felt comfortable completing. As mentioned previously, I started my systematic review on a few occasions, not really completing it until I had allocated myself some protected time and in truth could see a deadline approaching. While there were some legitimate reasons for delaying it, there were also missed opportunities, where I possibly could have started it but prioritised other things. It was a challenge to engage in a piece of work that didn't involve real life participants, and I know procrastination certainly had a

part to play. As I move forward, as a qualified member of staff, I envisage conducting research within the specialities in which I work. I feel that the experience of completing this competency has given me many examples of how to structure my time better, consult with those supporting me throughout, not just when I hit roadblocks and to always have a contingency plan!

Chapter 5: Professional Development

Reflective Practice Commentary

I am delighted and proud that I'm at the point of completing my final piece for the doctorate in health psychology. As I think back to applying, getting an interview and being successful in achieving a place on the course, on one hand it seems like it was just yesterday yet so much has happened since that first visit to Liverpool! As I started the Professional Doctorate in Health Psychology, I was full of enthusiasm and while that enthusiasm hasn't dwindled, it certainly waned slightly with the pressure of travelling, studying, work life, and the uncertainties of life.

Meeting the demands of the course was not always easy. Starting the course in January 2019, I was determined that I would complete it by January 2021. Unfortunately, I have passed this deadline, but as I reflect on the past few years, I'm delighted to be approaching the finish line.

As I now approach the end of the course I am looking forward to having some time where I don't have to be so organised. While it has been stressful, it has also been enlightening; in a normal working week, I seldom take time to reflect on the latest literature, feeling that there is limited time to do so. The course forced me to do this and more outside of work, and as a result made me question our current work practices and whether they should be modified. Within our department there is a tendency to keep doing things as they've always been done. Stepping outside of the department and reflecting on these practices has allowed me to question this. In the last year, many work practices have been adjusted to meet the demands of a changing workforce in the light of Covid-19 and while this has been an adjustment I also feel it is healthy for the

department as a whole to really examine what actually works for us and what we continue with simply out of habit. Changing working practices is uncomfortable. While most of us like to maintain the status quo, there is the flexibility to consider and possibly embrace change. Unfortunately, this is not the case for everyone, and this can be stressful and possibly met with resistance. This is a challenge and requires careful management. It also highlights the need for continuous reflection. I have struggled at times with the degree of reflection required by the course; however, it is a useful tool in that it encourages ongoing evaluation of practice. So, while the doctorate has given me lots of opportunity to learn from the patients I have worked with, it, alongside Covid, has also presented the opportunity for me to learn so much more about working with others, particularly during difficult times in both their personal and professional life. It has highlighted the need for establishing and maintaining boundaries both with patients and colleagues. I am more aware of the need to be tolerant of others and how they adapt to situations, of the need for me to be more tolerant of change.

What I have learned about myself during this time is that I tend to prioritise patient work over everything else. I feel that patient work is important and forms the foundations of what we do I realise that I also need to be more mindful about attending continuing professional development (CPD) to make sure that I keep up to date with current practices. I also need to read more around the areas of work that I already know well, because despite knowing them well, ongoing research in these areas offers fresh insights. I have used the excuse in the past that I am too busy with patients for these aspects of my work, but this past two years has highlighted for me how these are essential elements that I need to prioritise and build into my job plan going forward.

My work with patients tends to be eclectic, and while I have some training in cognitive behavioural therapy which informs much of what I do, I also have some training in Acceptance and Commitment Therapy (ACT), Solution Focused Therapy, Hypnotherapy and Thought Field Therapy. All of these are underpinned by a person-centred approach which means that I tend to use elements of most of these therapies as and when needed rather than sticking purely to any one particular treatment modality. I feel that this is an entirely patient-centred way to work and while each therapy that I have detailed has its merits I think as individuals we are also very different from day-to-day and situation to situation therefore, one particular therapy may not always be useful and sometimes using a collaborative approach allows the patient to be able to view their situation differently in a safe and controlled way. As I am reflecting on this now, I realise that my prioritising patients is about wanting to give as much as possible to those in distress. However, by not keeping up to date with the newest research or updating my CPD record, I am potentially not giving my patient everything that they deserve and that does not sit well with me. So, I think this is really something that I need to be very clear on as I move forward, I know that I spoke to Helen, my supervisor, on at least two occasions about not meeting deadlines I had set for myself because I had prioritised patient work and managing waiting lists within the clinic ahead of my studies. Taking time now to look at that more clearly, it makes absolutely no sense at all because it might have meant that I felt it was appropriate to allow my patients to be seen by a member of staff (me), who did not have full training rather than move towards completing my training sooner.

In my training log, I referred to the death of our secretary's son [redacted]. As I write about it, I can feel my emotions rising to the surface. I mentioned that I felt that his death really should not have had such an impact on me, but it was beyond anything that

I could have imagined. [redacted] When I look back on that time now, [redacted] I think about professional boundaries, there was a distinct lack of them present that day. Although we weren't there as psychologists, we also didn't fit the remit of friends but were treated as part of the family. [redacted] I know that it impacted on me significantly that day and for the weeks following, [redacted], it continues to impact on me both personally and professionally. This is highlighted in the HCPC Standards of Proficiency for practitioner psychologists in section 2.10 where it is stated that practitioner psychologists need to "be able to recognise appropriate boundaries and understand the dynamics of power relationships", which is something that we did not take into account on this occasion. Going back to how I prioritise patient work, this was also the case the morning after his death, as we had a pain management programme in its second week. It was offsite and we had no way of notifying the patients, so we had to proceed with the programme. As much as I enjoy delivering the pain management programme, you really have to be on top form, which I definitely wasn't, so I prioritised my patients but possibly not to their benefit as they probably didn't get the best from me that day. In hindsight, it might have been wiser to cancel the programme and reschedule it, and again looking at the HCPC standards which state that practitioner psychologist must be able to maintain a fitness to practice, and understand the importance of maintaining

their own health, this is an area that I was not fully cognizant of at that time. It was only following the event that I was aware of this as I engaged in my reflective log.

This incident, which happened outside of our department continues to impact to this day. [redacted] In doing so she transferred that vulnerability to me, which resulted in me doubting my ability as a professional for quite some time thereafter and had a negative impact on my confidence at that time. Thinking about that now makes me angry, angry at myself for not managing the situation better, angry [redacted] me feel vulnerable, which resulted in me cancelling a presentation I was due to give at a conference the following week. However, I am now grateful for the experience, regardless of how emotionally difficult it was for me at the time. It has made me determined to manage similar situations in a different way from the outset and has highlighted the role of boundaries for all parties. I also feel that it has made me a stronger person overall, and one that has more confidence in her professional role and is not afraid to accept that role. In the past, I saw myself as the junior member of staff as I was not 'fully qualified', over the past two years, as I have moved towards my

qualification, I have become more aware of my strengths, personally and clinically and am now more likely to implement them rather than waiting for my 'fully qualified' colleagues to do so. There will always be a hierarchy within any department and in Healthcare and, while I will maintain respect, I am also now more confident to make my opinions heard.

[redacted] Again, this highlights how important it is to develop and maintain boundaries with patients and colleagues alike. Having previously established strong boundaries with this member of staff, they were undermined by some of my other colleagues, not having similar boundaries in place. This illustrates my lack of confidence to assert myself in the presence of other qualified staff, but it also highlights the desire in me, as in many healthcare staff to help others. However, when clear boundaries are in place it is much easier to see that helping others does not always mean giving them what they want but taking the time to reflect and identify what they actually *need*.

So, the first year of this doctorate was like a roller coaster but it really highlighted for me the importance of supervision not just for focusing on clinical aspects of the work but for identifying all the other areas of life that impact on work and that need to be

taken into account in order to be the most effective practitioner. While I have confidence in my ability to work therapeutically with patients, I think that not having progressed my training until this point meant that I was not fully confident in my interactions with other health professionals. In this last year, as I am approaching my qualification in health psychology, I am more confident in my ability as a professional in my interactions with patients, and maybe more importantly other healthcare staff. This allows me to meet one of the standards (9.7) set out in the HCPC Standards of Proficiency for practitioner psychologists, in that I am now more able to contribute effectively to work undertaken as part of a multi-disciplinary team, as a result of increased self-belief.

As I moved beyond the stress of the first year of the doctorate and considered the second year where I would have less travel and therefore more time to engage in achieving my competencies, I felt reinvigorated. I planned a week of annual leave in January to get focused and plan the year ahead. I started this with a plan that was over ambitious to say the least, however had to adjust that plan as my daughter was unwell and off school for the latter part of that week. Having been annoyed initially at the intrusion her illness was creating in my plans, I had to adjust and reassess what was important at the time. As the year moved slowly towards March and I made some progress in my competencies, I felt that I was starting to gain more momentum and was using my study day effectively, and was excited at the prospect of embracing case studies etc. Unfortunately, Covid 19 created a sense of uncertainty and panic across the world and particularly within healthcare and most hospital-based services were impacted on as a result. For me that meant the suspension of clinics initially, a change in working practices including working from home and working different days and hours,

all of which required flexibility. But for me it also meant that academic work was pushed to the side as I assisted in the department's response to Covid within our Trust. I reassured myself that it wouldn't be an issue, that I would just need to apply myself more in the evenings, however, I did not feel I had the energy reserves I needed for this and whether it was a physical or emotional fatigue, it got in the way of me applying myself fully to my studies.

The role of health psychology came a little more into focus throughout the pandemic, with health psychologists contributing to the guidance issued by the government as to how we should respond, and this is something that I felt was very positive. Previously, in wider psychology team meetings, I often had the sense that physical health psychology was viewed as the 'easy' option, while working in some of the other speciality areas were much more challenging. For me this is not the case, but I feel that the role of health psychologists within the response to Covid 19 highlighted the importance of our profession to those who may have been sceptical in the past. This in turn has an impact on me professionally as there is a greater spotlight on the role of health psychologists which I feel promotes and possibly validates my role as a health psychologist in training. Unfortunately, we have been unable to hold wider psychology team meetings as we used to, however, I feel that regardless of others' perceptions of my role as a trainee health psychologist, my increased confidence allows me to express my opinions in a more assertive way.

The patients that I work with daily present with challenges that many of us would struggle to manage both physically and emotionally. They are often at their most vulnerable, feeling as if they have failed, and their mood is a factor which needs some

attention. In essence many of these individuals exhibit multiple physical and mental health co-morbidities, often have limited family and social support networks, and often lack insight and struggle to comply with treatment plans designed to have a positive impact on their physical health. For me the role of the health psychologist encompasses many distinct areas of work, such as patient work, multi-disciplinary working, consultation and health promotion and is certainly not the 'easy option', but it is a fulfilling role despite the challenges. This excites me, the work is varied and challenging, allowing me to work with a wide range of individuals, and balance working with patients while also embracing the scientist practitioner in me.

I have noticed on other occasions where I have been studying that there is an inherent desire (I suspect in most of us) for the familiar. This can allow for complacency and work practices that are comfortable and safe. This can allow us to 'trundle' along, without question, to continue certain practices without evaluation and become less mindful of our daily practices. In a work setting such as health psychology, this 'familiar' place, may not be conducive to providing best practice and is something that needs continual evaluation. For me, studying forces me to step out of the familiar way in which I've been working and that is positive. For many of the individuals we see, attending our services forces them to do the same thing, to step outside of their comfort zone, and to evaluate how they are coping with their current situation. The hope is that this allows them to identify alternative ways of coping and continue managing their condition and improve their quality of life; for me studying creates a similar environment. On this occasion, studying for the doctorate felt comfortable, and right, and I felt confident (most of the time) about it. The challenges that I encountered earlier in 2019 knocked my confidence but I feel that I was able to move on and get back to enjoying studying. The difficulty for

me was that, despite enjoying the study and increasing my confidence as a psychologist, there were still other aspects of working life that were difficult. Reflecting on this recently I was aware that I possibly learned as much from the people I work with as I have from the patients. Also, if someone had told me in January 2019 that I would encounter the challenges that I have over the past two years, I would likely have postponed starting the course. That would have been a mistake. Despite this past two years having been difficult, I think life always presents challenges which cannot always be planned for. What we can do, and what I have done over the past two years is accept the challenges that are presented, adapt and move forward. We ask our patients to do this every day, without really considering how difficult this might be for them. What the past two years has done is bombard us as a population and me personally with challenges I never imagined possible. But in doing so, it has highlighted both my vulnerabilities and strengths. I normally ask my patients to be aware of both but to engage more fully with the strengths if they can. This course has made me do just that and I'm now starting to wonder if I have been doing precisely what our secretary is currently doing and avoiding facing my vulnerabilities until now. Going forward, without the structure of the doctorate to motivate me to continue my professional development, I plan to set myself goals each month, such as maintaining the reflective practice log, reading at least one new research article each month, and possibly to establish a reflective practice element to our team meetings. This would allow not just me, but other members of staff, to have a structure and support around continuing professional development.

There were moments throughout the course when I was aware of questioning my motivation for enrolling on the course – should I continue with it? Was my motivation

about title/pay grade? Was I simply being indulgent? At these times, I was aware of my potential ability to self-sabotage. The desire to achieve my full potential, to illustrate to my children that it's never too late to follow your dreams, that it is possible to achieve a good work-life balance and that hard work does indeed pay off, won through. Again, I think that this is a process that many of our clients/patients must experience as they attend any of our services and face difficult sessions, and for me, I found it was an important exercise to identify with that struggle and be able to continue. I don't think that my children have taken anything positive from my studies though, as they have commented on numerous occasions about my "studying again". Initially this made me question if my goal of showing them that you can follow your dreams at any stage was actually being achieved. It also made me feel a little guilty, as the tone used suggested that I was focusing a lot of attention on studies and maybe not so much on my family. However, as a teenager I might not have understood it either. I think that it will allow them to see that education and achieving your goals does not have to be a linear experience but one that you can make fit your own scenario, even if they don't see that just now.

Throughout the course and particularly in striving towards the research competency, I found that there were several occasions where I felt quite vulnerable. While no-one is particularly comfortable identifying their vulnerabilities and weaknesses, it is only in doing so that we can address them and build on these so that hopefully they become strengths rather than weaknesses. While having previous experience of research and methods and statistics modules, I have never been particularly comfortable in this area. And while there were legitimate reasons for my not starting my research competency sooner, I feel that sub-consciously, I may have been delaying it for as long as possible

too. Logically, I know that delaying it only prolongs the agony but I didn't see that at the time. As I approached the end of the doctorate with my research competency outstanding I felt overwhelmed and annoyed at myself for not addressing it sooner, however, I know that particularly for the systematic review, I would have been unable to do it justice in the first year and even in the first part of the second year. So, feeling vulnerable to begin with, topped off with a side of being overwhelmed made for a very difficult and stressful few weeks towards the end of the course. While I made it work by utilising a dedicated block of time, it meant that I was totally immersed in studying during that time. The other activities that I enjoy, and that I know help me manage stress, all fell to the wayside. Again, I found myself drawing comparisons with my patients, who often describe similar scenarios, and I advise them to engage in more of the activities that they enjoy; ironic, then, that I wasn't able to 'practice what I preach'.

I was also challenged when it came to conducting my research. This involved a qualitative evaluation of the implementation of behaviour change skills training. Despite having worked with these staff previously, some of the participants appeared resistant to participate fully despite having volunteered to do so. This made me step outside my comfort zone in one way, as I adapted the interview style to manage this resistance, it also highlighted that I possibly possess negotiation skills that I was unaware of, or have avoided identifying prior to this course. As I reflect on this, these are skills that I have drawn on previously during patient contacts, again with patients who were initially resistant to engaging with psychology. There have been occasions where patients have been less than forthcoming with relevant information in assessment, and these have turned out to be some of the most rewarding assessments. Shifting gear, moving away from the standard assessment questions and engaging in a conversation

about a topic of interest for the patient often yields richer and more appropriate information than they might have intended to share. However, having engaged them in this way, allows them to see that you identify with them as an individual and have an ability to understand their situation, thereby taking away some of the 'unknowns' of attending a consultation with a psychologist. I feel it levels the playing field and allows both the patient and me to enter into a more comfortable working relationship.

Having regular supervision, both clinically and academically helped address my concerns and made me face my vulnerabilities and as a result, and increased my confidence overall. However, there is also something to be said for blocks of time that are dedicated solely to study. With my research, I started it on a number of occasions, and, yes, in the first year there were some events that were outside of my control that postponed my getting started properly. There was also a lack of dedicated time which I felt made it difficult for me to get started, particularly when I think about the systematic review. I started that on a few occasions with the intention of going back and doing another piece in the next day. I also told myself that if I got it started, I would be able to do more focused work on it at the weekend, but that never happened for me. It was only towards the end of the course when I had quite a block of annual leave built up that I was really able to use the time to fully focus and work through those elements such as a systematic review without any distractions. So, it is useful to have regular supervision and small gains throughout the doctorate, but for me was there was no question that a block of time dedicated solely to a particular piece of work was useful, if not necessary. Going forward, this is something that I will be mindful of as I plan any larger pieces of research at work. Looking back, I might have benefitted from combining my study days each month and having a set block of time away from patient work to focus on the academic

side of things each month. This would allow me to plan my time more constructively and avoid raising anxiety as work would not be avoided or delayed.

During the doctorate, I also completed several tasks that would not usually be part of my current workload, and as such felt quite challenged in these moments. The consultancy competency is an example. The initial stage of this assignment was new to me, and I found it challenging just to know how much or little information was required. I also consulted on a project that was developed by someone I knew well in another aspect of life and that interested me. While I felt that having an interest in the area was important, I feel that the familiarity I had with the consultee possibly made the task more difficult at times. This might have been down to me assuming that I knew what they wanted and not clarifying this fully but it could also have been the fact that the consultee knew me in a different role and found it difficult to interact or trust me in the role of a trainee health psychologist. It was a learning experience for sure, and one that will stay with me, in terms of how not to do it in the future.

I would be without hesitation in advising anyone considering the Professional Doctorate in Health Psychology to sign up for it. Yes, it was a difficult few years, and preparing, submitting and waiting for results of coursework was not easy, but it was worthwhile. It certainly took a some of adjustment to get used to a different way of studying but the level of organisation and assistance readily available made that much easier than I had anticipated. It has made me consider current working practices and in addressing strengths and weaknesses allowed me to assert myself within my own professional group, as well as in the wider multi-disciplinary teams within the hospital.

Training Log

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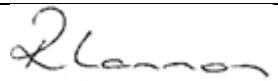
Trainee Name: Tracy McCrossan Supervisors: Dr Mary Dooher/Dr Rosa Lannon	Placement Type: Health Psychology Placement Dates: 17th January 2019 – 17th January 2021 Date: **Week Commencing 21st January 2019**

Case No.	Demographics (e.g. gender, age, ethnicity)	Referred by	Main Problems	Outline the intervention undertaken, including main treatment modes and any relevant additional information	Formal Evaluation measures used?	Was the work recorded/observed?	No of sessions	Case complete or ongoing?
1(21.1.19)	Male, White,	GP	Adjustment to COPD	CBT/ACT	HADS		2	Ongoing
2(21.1.19)	Female, White	DSN	Coping with lifestyle change in Diabetes	CBT/Psychoeducation/Relaxation therapy	HADS		3	Ongoing
3(22.1.19)	Male & Female Group x14	Cons Anaesthetist	Coping with Chronic Pain	MDM approach involving psychology, Physiotherapy and Occupational Therapy, delivering a CBT based educational programme	PSEQ4+2 HADS		Session 2 of 8	Ongoing

				to encourage behaviour change and better self-management.				
4(23.1.19)	Female, white	BCN	Coping with Ca diagnosis	Supportive Counselling	HADS		5	Ongoing
5(23.1.19)	Female, white	BCN	Coping with Ca diagnosis	Supportive Counselling	HADS		1	Ongoing
6(23.1.19)	Male, White	GP	Lifestyle change required secondary to Diabetes	CBT/ACT	HADS		3	Ongoing
7(23.1.19)	Male, white	Other Psychologist	Needle Phobia & Anxiety	Hypnotherapy/CBT	HADS		48	Ongoing



Trainee Name: Tracy McCrossan Supervisors: Dr Mary Dooher/Dr Rosa Lannon	Placement Type: Health Psychology Placement Dates: 17th January 2019 – 17th January 2021 Date: **Week Commencing 28th January 2019**

Case No.	Demographics (e.g. gender, age, ethnicity)	Referred by	Main Problems	Outline the intervention undertaken, including main treatment modes and any relevant additional information	Formal Evaluation measures used?	Was the work recorded/observed?	No of sessions	Case complete or ongoing?
1(28.1.19)	Male, White,	Renal Nurse	Anxiety secondary to renal transplant	Anxiety Management/Psychoeducation	HADS		5	Ongoing
2(28.1.19)	Female, White	Resp Nurse	Coping with lifestyle change in COPD	CBT/ACT	HADS		7	Ongoing
3(28.1.19)	Male	GP	Lifestyle change in Diabetes	CBT	HADS		2	Ongoing
4(28.1.19)	Male, white	Oncologist	Coping with Ca diagnosis	Supportive Counselling	HADS		10	Ongoing

5(29.1.19)	Male & Female Group x 12	Cons Anaesthetist	Coping with Chronic Pain	MDM approach involving psychology, Physiotherapy and Occupational Therapy, delivering a CBT based educational programme to encourage behaviour change and better self-management.	PSEQ4+2 HADS		Session 3 of 8	Ongoing
6(30.1.19)	Male, white	Pharmacist	Lifestyle change in Diabetes	CBT	HADS		6	Ongoing
7(30.1.19)	Female, White	Pharmacist	Lifestyle change required secondary to Diabetes	CNA appt	HADS		4	Ongoing
8(31.1.19)	Female, white	Resp Nurse	Anxiety and coping	Anxiety Management/Relaxation	HADS		1	Ongoing
9(31.1.19)	Female, white		Lifestyle Change	Goal Setting & Behavioural activation	HADS		1	Ongoing

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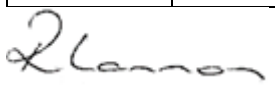
Trainee Name: Tracy McCrossan Supervisors: Dr Mary Dooher/Dr Rosa Lannon	Placement Type: Health Psychology Placement Dates: 17th January 2019 – 17th January 2021 Date: **Week Commencing 4th February 2019**

Case No.	Demographics (e.g. gender, age, ethnicity)	Referred by	Main Problems	Outline the intervention undertaken, including main treatment modes and any relevant additional information	Formal Evaluation measures used?	Was the work recorded/observed?	No of sessions	Case complete or ongoing?
1(04.2.19)	Male, White,	GP	Adjustment to COPD	CBT/ACT	HADS		3	Ongoing
2(05.2.19)	Male & Female Group x 11	Cons Anaesthetist	Coping with Chronic Pain	MDM approach involving psychology, Physiotherapy and Occupational Therapy, delivering a CBT based educational programme to encourage behaviour change and better self-management.	PSEQ4+2 HADS		Session 4 of 8	Ongoing
3(06.2.19)	Female, white	BCN	Coping with Ca diagnosis	Supportive Counselling	HADS		2	Ongoing

4(06.2.19)	Male, White	GP	Lifestyle change required secondary to Diabetes	CBT/ACT	HADS		7	Ongoing
5(06.2.19)	Female, white	Renal Nurse	Coping with dialysis	ACT/Relaxation	HADS		1	Ongoing



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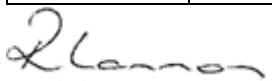
Trainee Name: Tracy McCrossan Supervisors: Dr Mary Dooher/Dr Rosa Lannon	Placement Type: Health Psychology Placement Dates: 17th January 2019 – 17th January 2021 Date: **Week Commencing 11th February 2019**

Case No.	Demographics (e.g. gender, age, ethnicity)	Referred by	Main Problems	Outline the intervention undertaken, including main treatment modes and any relevant additional information	Formal Evaluation measures used?	Was the work recorded/observed?	No of sessions	Case complete or ongoing?
1 (11.02.2019)	Male, white	Cons Oncologist	Coping Terminal Ca diagnosis	Supportive Counselling	HADS		11	Ongoing
2 (12.02.2019)	Male and female group x 11	Cons Anaesthetist	Coping with Chronic Pain	MDM approach involving psychology, Physiotherapy and Occupational Therapy, delivering a CBT based educational programme to encourage behaviour change and better self-management.	PSEQ4+2 HADS		Session 5 of 8	Ongoing
3 (13.2.2019)	Female, white	Breast Care Nurse	Coping Ca diagnosis	Supportive Counselling/ACT	HADS		6	Ongoing
4 (13.02.2019)	Female, White				HADS		1	Ongoing
5 (13.02.2019)	Male, White	Renal Nurse	Coping with life after transplant	ACT/CBT	HADS		6	Ongoing

6 (13.02.2019)	Female, White	Resp Cons	Coping Diagnosis of Sarcoidosis. Lifestyle Change	Psychoeducation/assertiveness training/CBT	HADS		1	Ongoing
7 (14.02.2019)	Female, White	DSN	Coping Diabetes/ Small vessel cardiac condition	Supportive Counselling/CBT	HADS		14	Ongoing



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Trainee Name: Tracy McCrossan Supervisors: Dr Mary Dooher/Dr Rosa Lannon	Placement Type: Health Psychology Placement Dates: 17th January 2019 – 17th January 2021 Date: **Week Commencing 18th February 2019**

Case No.	Demographics (e.g. gender, age, ethnicity)	Referred by	Main Problems	Outline the intervention undertaken, including main treatment modes and any relevant additional information	Formal Evaluation measures used?	Was the work recorded/observed?	No of sessions	Case complete or ongoing?
1(18.02.19)	Female	Resp Nurse	COPD coping	Behavioural Activation	HADS		3	Ongoing
2(18.02.19)	Female	Staff Nurse	Renal coping dialysis	Supportive Counselling	HADS		2	Ongoing
4(19.2.19)	Male & Female Group	Cons Anaesthetist		MDM approach involving psychology, Physiotherapy and Occupational Therapy, delivering a CBT based educational programme to encourage behaviour change and better self-management.	PSEQ4+2 HADS		Session 6 of 8	Ongoing

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Trainee Name: Tracy McCrossan Supervisors: Dr Mary Dooher/Dr Rosa Lannon	Placement Type: Health Psychology Placement Dates: 17th January 2019 – 17th January 2021 Date: **Week Commencing 25th February 2019**

Case No.	Demographics (e.g. gender, age, ethnicity)	Referred by	Main Problems	Outline the intervention undertaken, including main treatment modes and any relevant additional information	Formal Evaluation measures used?	Was the work recorded/observed?	No of sessions	Case complete or ongoing?
1(25.02.19)	Male	GP	Diabetes Management	Solution Focused Therapy	HADS		4	Ongoing
2(25.02.19)	Female	DSN	Diabetes Management	Behavioural activation	HADS		5	Ongoing
3(25.02.19)	Female	Resp Nurse	Asthma coping	Solution Focused Therapy	HADS		8	Ongoing
4(25.02.19)	Male	Oncologist	Coping with diagnosis	Supportive Counselling	HADS		12	Ongoing
5(26.2.19)	Male & Female Group	Cons Anaesthetist		MDM approach involving psychology, Physiotherapy and Occupational Therapy, delivering a CBT based educational programme	PSEQ4+2 HADS		Session 7 of 8	Ongoing

				to encourage behaviour change and better self-management.				
6(27.02.19)	Female	Oncologist	Coping with diagnosis	Supportive Counselling	HADS		3	Ongoing
7(27.02.19)	Female	Other Cons	Coping LTC	Solution Focused Therapy	HADS		3	Ongoing
8(27.02.19)	Male	GP	Diabetes Management/ weight loss	CBT/Behavioural Activation	HADS		4	Ongoing
9(28.02.19)	Female	Resp Cons	Coping with new diagnosis Sarcoidosis	Supportive Counselling	HADS		4	Ongoing

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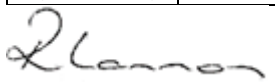
Trainee Name: Tracy McCrossan Supervisors: Dr Mary Dooher/Dr Rosa Lannon	Placement Type: Health Psychology Placement Dates: 17th January 2019 – 17th January 2021 Date: **Week Commencing 4th March 2019**

Case No.	Demographics (e.g. gender, age, ethnicity)	Referred by	Main Problems	Outline the intervention undertaken, including main treatment modes and any relevant additional information	Formal Evaluation measures used?	Was the work recorded/observed?	No of sessions	Case complete or ongoing?
1(04.03.19)	Female	Staff nurse	Renal, coping dialysis	Solution Focused therapy	HADS		3	Ongoing
3(04.03.19)	Male and Female Group x 7	Self Selected Focus Group	Chronic Pain	Focus Group			1	Ongoing
4(05.3.19)	Male & Female Group	Cons Anaesthetist	Chronic Pain	MDM approach involving psychology, Physiotherapy and Occupational Therapy, delivering a CBT based educational programme to encourage behaviour change and better self-management.	PSEQ4+2 HADS		Session 8 of 8	Discharged
5(06.03.19)	Male	Pharmacist	Diabetes/Coping	Behavioural Activation	HADS		8	Ongoing

6(06.03.19)	Female	Breast Care Nurse	Coping with diagnosis	Supportive COUNSELLING	HADS		7	Ongoing
7(06.03.19)	Male	Staff Nurse	Renal/coping	Solution Focused Therapy	HADS		7	Discharged



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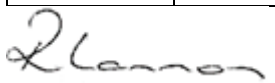
Trainee Name: Tracy McCrossan Supervisors: Dr Mary Dooher/Dr Rosa Lannon	Placement Type: Health Psychology Placement Dates: 17th January 2019 – 17th January 2021 Date: **Week Commencing 11th March 2019**

Case No.	Demographics (e.g. gender, age, ethnicity)	Referred by	Main Problems	Outline the intervention undertaken, including main treatment modes and any relevant additional information	Formal Evaluation measures used?	Was the work recorded/observed?	No of sessions	Case complete or ongoing?
1(11.03.19)	Male	GP	Diabetes Management	Solution Focused Therapy	HADS		5	Discharged
2(11.03.19)	Female	DSN	Diabetes/coping	Behavioural Activation	HADS		6	Ongoing
3(13.03.19)	Female	Pharmacist	Diabetes/acceptance	Assessment	HADS		1	Ongoing
4(13.03.19)	Female	Cons Oncologist	Coping with diagnosis	Supportive Counselling/TFT	HADS		3	Ongoing
5(14.03.19)	Female	Resp Cons	Coping diagnosis Sarcoidosis	CAN/SFA	HADS			Ongoing



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Trainee Name: Tracy McCrossan Supervisors: Dr Mary Dooher/Dr Rosa Lannon	Placement Type: Health Psychology Placement Dates: 17th January 2019 – 17th January 2021 Date: **Week Commencing 19th March 2019**

Case No.	Demographics (e.g. gender, age, ethnicity)	Referred by	Main Problems	Outline the intervention undertaken, including main treatment modes and any relevant additional information	Formal Evaluation measures used?	Was the work recorded/observed?	No of sessions	Case complete or ongoing?
1(20.03.19)	Male & Female Group	Cons Anaesthetist	Chronic Pain	MDM approach involving psychology, Physiotherapy and Occupational Therapy, delivering a CBT based educational programme to encourage behaviour change and better self-management.	PSEQ4+2 HADS		Session 1of 8	Ongoing

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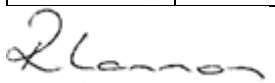
Trainee Name: Tracy McCrossan Supervisors: Dr Mary Dooher/Dr Rosa Lannon	Placement Type: Health Psychology Placement Dates: 17th January 2019 – 17th January 2021 Date: **Week Commencing 25th March 2019**

Case No.	Demographics (e.g. gender, age, ethnicity)	Referred by	Main Problems	Outline the intervention undertaken, including main treatment modes and any relevant additional information	Formal Evaluation measures used?	Was the work recorded/observed?	No of sessions	Case complete or ongoing?
1(26.03.19)	Male & Female Group	Cons Anaesthetist	Chronic Pain	MDM approach involving psychology, Physiotherapy and Occupational Therapy, delivering a CBT based educational programme to encourage behaviour change and better self-management.	PSEQ4+2 HADS		Session 2 of 8	Ongoing
2(27.03.19)	Male	GP	Diabetes Management	Assessment	HADS		1	Ongoing

3(27.03.19)	Female	GP	Health anxiety following Ca diagnosis	Assessment	HADS		1	Ongoing
4(27.03.19)	Male	Endocrinologist	Diabetes management	Assessment	HADS		1	Ongoing
5(28.03.19)	Male	DSN	Diabetes poor control	Assessment	HADS		1	Ongoing
6(28.03.19)	Female	Breast Care Nurse	Coping with diagnosis	Assessment	HADS		1	Ongoing
7(28.03.19)	Male	Endocrinologist	Diabetes control	Assessment	HADS		1	Ongoing



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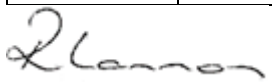
Trainee Name: Tracy McCrossan Supervisors: Dr Mary Dooher/Dr Rosa Lannon	Placement Type: Health Psychology Placement Dates: 17th January 2019 – 17th January 2021 Date: **Week Commencing 1st April 2019**

Case No.	Demographics (e.g. gender, age, ethnicity)	Referred by	Main Problems	Outline the intervention undertaken, including main treatment modes and any relevant additional information	Formal Evaluation measures used?	Was the work recorded/observed?	No of sessions	Case complete or ongoing?
1(01.04.19)	Male	GP	Adjustment to COPD	ACT/CBT	HADS		4	Ongoing
2(01.04.19)	Female	GP	Diabetes management	CBT	HADS		7	Ongoing
3(01.04.19)	Female	Resp Cons	Coping with diagnosis	Solution Focused Therapy	HADS		5	
4(02.04.19)	Male & Female Group	Cons Anaesthetist	Chronic Pain	MDM approach involving psychology, Physiotherapy and Occupational Therapy, delivering a CBT based educational programme to encourage behaviour change and better self-management.	PSEQ4+2 HADS		Session 3 of 8	Ongoing
5(02.04.19)	Female	Renal	Coping with Dialysis	Solution Focused Therapy	HADS		4	Discharged
6(03.04.19)	Female	Oncologist	Coping with diagnosis	Supportive counselling/CBT	HADS		8	Ongoing

7(03.04.19)	Male	GP	Diabetes Management	CBT/Behavioural Activation	HADS		5	Ongoing



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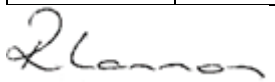
Trainee Name: Tracy McCrossan Supervisors: Dr Mary Dooher/Dr Rosa Lannon	Placement Type: Health Psychology Placement Dates: 17th January 2019 – 17th January 2021 Date: **Week Commencing 8th April 2019**

Case No.	Demographics (e.g. gender, age, ethnicity)	Referred by	Main Problems	Outline the intervention undertaken, including main treatment modes and any relevant additional information	Formal Evaluation measures used?	Was the work recorded/observed?	No of sessions	Case complete or ongoing?
1(08.04.19)	Male	Oncologist	Coping diagnosis mesothelioma	Supportive Counselling	HADS		13	Ongoing
2(08.04.19)	Male	DSN	Poor diabetes control	CBT	HADS		2	Ongoing
3(05.2.19)	Male & Female Group	Cons Anaesthetist		MDM approach involving psychology, Physiotherapy and Occupational Therapy, delivering a CBT based educational programme to encourage behaviour change and better self-management.	PSEQ4+2 HADS		Session 4 of 8	Ongoing
4(10.04.19)	Female	Cons Oncologist	Coping with diagnosis	Supportive Counselling/TFT	HADS		4	Ongoing

5(10.04.19)	Female	Pharmacist	Poor control diabetes	CBT/ACT	HADS		2	Ongoing
6(11.04.19)	Female	Breast Care Nurse	Coping with diagnosis	Solution focused therapy	HADS		2	Ongoing
7(11.04.19)	Male	Endocrinologist	Diabetes Control	CBT	HADS		2	Ongoing



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Trainee Name: Tracy McCrossan Supervisors: Dr Mary Dooher/Dr Rosa Lannon	Placement Type: Health Psychology Placement Dates: 17th January 2019 – 17th January 2021 Date: **Week Commencing 15th April 2019**

Case No.	Demographics (e.g. gender, age, ethnicity)	Referred by	Main Problems	Outline the intervention undertaken, including main treatment modes and any relevant additional information	Formal Evaluation measures used?	Was the work recorded/observed?	No of sessions	Case complete or ongoing?
1(15.04.19)	Female	Resp Cons	Coping with diagnosis Sarcoidosis	CBT/Supportive Counselling	HADS		6	Ongoing
(15.04.19)	Male	GP	Diabetes management	CBT	HADS		6	
2(05.2.19)	Male & Female Group	Cons Anaesthetist	Chronic Pain	MDM approach involving psychology, Physiotherapy and Occupational Therapy, delivering a CBT based educational programme to encourage behaviour change and better self-management.	PSEQ4+2 HADS		Session 5 of 8	Ongoing

3(17.04.19)	Male	Pharmacist	Poor control Diabetes	CNA	HADS		8	Ongoing
4(17.04.19)	Male	Endocrinologist	Diabetes Management	CBT	HADS		2	Ongoing
5(17.04.19)	Male	Endocrinologist	Diabetes Poor Control	CBT	HADS		3	Discharged
6(18.04.19)	Male & Female Group x 7	Pulmonary Rehab Nurse	Coping with respiratory condition	Psycho-education			1	Discharged

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Trainee Name: Tracy McCrossan Supervisors: Dr Mary Dooher/Dr Rosa Lannon	Placement Type: Health Psychology Placement Dates: 17th January 2019 – 17th January 2021 Date: **Week Commencing 22nd April 2019**

Case No.	Demographics (e.g. gender, age, ethnicity)	Referred by	Main Problems	Outline the intervention undertaken, including main treatment modes and any relevant additional information	Formal Evaluation measures used?	Was the work recorded/observed?	No of sessions	Case complete or ongoing?
ANNUAL LEAVE					HADS			Ongoing

R Lannon

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Trainee Name: Tracy McCrossan Supervisors: Dr Mary Dooher/Dr Rosa Lannon	Placement Type: Health Psychology Placement Dates: 17th January 2019 – 17th January 2021 Date: **Week Commencing 29th April 2019**

Case No.	Demographics (e.g. gender, age, ethnicity)	Referred by	Main Problems	Outline the intervention undertaken, including main treatment modes and any relevant additional information	Formal Evaluation measures used?	Was the work recorded/observed?	No of sessions	Case complete or ongoing?
1(29.04.19)	Male	Oncologist	Coping with diagnosis	Assessment scheduled – CNA, On hold until tx complete				Ongoing
2(29.04.19)	Female	Oncologist	Coping with diagnosis	Assessment scheduled – CNA, on hold until tx complete				Ongoing
3(29.04.19)	Male	Oncologist	Coping with diagnosis mesothelioma	Supportive Counselling	HADS		14	Ongoing
4(29.04.19)	Male	GP	Diabetes Management	CBT	HADS		7	Discharged
5(30.04.19)	Male & Female Group	Cons Anaesthetist		MDM approach involving psychology, Physiotherapy and Occupational Therapy, delivering a CBT based	PSEQ4+2 HADS		Session 6 of 8	Ongoing

				educational programme to encourage behaviour change and better self-management.				
6(01.05.19)	Male	Endocrinologist	Poor diabetes control	CBT	HADS		2	Ongoing
7(01.05.19)	Female	Oncologist	Health Anxiety	CNA	HADS		1	Ongoing
8(01.05.19)	Female	Breast Care Nurse	Coping with diagnosis	Supportive counselling	HADS		8	Ongoing
9(01.05.19)	Male	Pharmacist	Coping with diabetes	CBT	HADS		9	Ongoing

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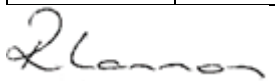
Trainee Name: Tracy McCrossan Supervisors: Dr Mary Dooher/Dr Rosa Lannon	Placement Type: Health Psychology Placement Dates: 17th January 2019 – 17th January 2021 Date: **Week Commencing 6th May 2019**

Case No.	Demographics (e.g. gender, age, ethnicity)	Referred by	Main Problems	Outline the intervention undertaken, including main treatment modes and any relevant additional information	Formal Evaluation measures used?	Was the work recorded/observed?	No of sessions	Case complete or ongoing?
1(07.05.19)	Male & Female Group	Cons Anaesthetist	Chronic Pain	MDM approach involving psychology, Physiotherapy and Occupational Therapy, delivering a CBT based educational programme to encourage behaviour change and better self-management.	PSEQ4+2 HADS		Session 7 of 8	Ongoing
2(09.05.19)	Female	Breast Care Nurse	Coping with diagnosis	Solution Focused Therapy	HADS		3	Ongoing
3(09.05.19)	Female	Resp Cons	Coping with diagnosis Sarcoidosis	CBT/Supportive Counselling	HADS		8	Ongoing
4(09.05.19)	Male	GP	Coping with COPD	Solution Focused Therapy	HADS		5	Ongoing



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Trainee Name: Tracy McCrossan Supervisors: Dr Mary Dooher/Dr Rosa Lannon	Placement Type: Health Psychology Placement Dates: 17th January 2019 – 17th January 2021 Date: **Week Commencing 13th May 2019**

Case No.	Demographics (e.g. gender, age, ethnicity)	Referred by	Main Problems	Outline the intervention undertaken, including main treatment modes and any relevant additional information	Formal Evaluation measures used?	Was the work recorded/observed?	No of sessions	Case complete or ongoing?
1(14.05.19)	Male & Female Group	Cons Anaesthetist	Chronic Pain	MDM approach involving psychology, Physiotherapy and Occupational Therapy, delivering a CBT based educational programme to encourage behaviour change and better self-management.	PSEQ4+2 HADS		Session 8 of 8	Ongoing
2(15.05.19)	Female	Resp Cons	Anxiety	Assessment	HADS		1	Ongoing
3(15.05.19)	Female	GP	Anxiety	Assessment	HADS		1	Discharged
4)15.05.19)	Female	GP	Health Anxiety	ACT	HADS		3	Ongoing

R Lannon

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Trainee Name: Tracy McCrossan Supervisors: Dr Mary Dooher/Dr Rosa Lannon	Placement Type: Health Psychology Placement Dates: 17th January 2019 – 17th January 2021 Date: **Week Commencing 20th May 2019**

Case No.	Demographics (e.g. gender, age, ethnicity)	Referred by	Main Problems	Outline the intervention undertaken, including main treatment modes and any relevant additional information	Formal Evaluation measures used?	Was the work recorded/observed?	No of sessions	Case complete or ongoing?
1(21.05.19)	Male	Oncologist	Coping with diagnosis mesothelioma	Supportive Counselling	HADS		15	Ongoing
2(20.05.19)				Psychology Team Meeting				
3(22.05.19)				Presentation to Trust staff regarding PPI focus groups conducted earlier in the year.				

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Trainee Name: Tracy McCrossan Supervisors: Dr Mary Dooher/Dr Rosa Lannon	Placement Type: Health Psychology Placement Dates: 17th January 2019 – 17th January 2021 Date: **Week Commencing 27th May 2019**

Case No.	Demographics (e.g. gender, age, ethnicity)	Referred by	Main Problems	Outline the intervention undertaken, including main treatment modes and any relevant additional information	Formal Evaluation measures used?	Was the work recorded/observed?	No of sessions	Case complete or ongoing?
1(28.05.19)	Male & Female Group	Cons Anaesthetist	Chronic Pain	Information Group	HADS PSEQ4+2			Ongoing
2(29.05.2019)	Male	Diab Nurse	Coping Diabetes	CBT	HADS		2	Ongoing

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Trainee Name: Tracy McCrossan Supervisors: Dr Mary Dooher/Dr Rosa Lannon	Placement Type: Health Psychology Placement Dates: 17th January 2019 – 17th January 2021 Date: **Week Commencing 3rd June 2019**

Case No.	Demographics (e.g. gender, age, ethnicity)	Referred by	Main Problems	Outline the intervention undertaken, including main treatment modes and any relevant additional information	Formal Evaluation measures used?	Was the work recorded/observed?	No of sessions	Case complete or ongoing?
1(04.06.2019)	Female, white	Oncologist	Coping diagnosis	ACT	HADS		1	Ongoing
2(05.06.2019)	Female	GP	Health Anxiety	Supportive Counselling	HADS		4	Ongoing
3(05.06.2019)	Male	Endocrinologist	Poor Diabetes Control	CBT	HADS		3	Ongoing
4(06.06.2019)	Female	Breast Care Nurse	Coping with diagnosis	Solution Focused Therapy	HADS		4	Ongoing
								Ongoing
								Ongoing

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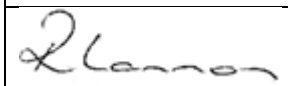
Trainee Name: Tracy McCrossan Supervisors: Dr Mary Dooher/Dr Rosa Lannon	Placement Type: Health Psychology Placement Dates: 17th January 2019 – 17th January 2021 Date: **Week Commencing 10th June 2019**

Case No.	Demographics (e.g. gender, age, ethnicity)	Referred by	Main Problems	Outline the intervention undertaken, including main treatment modes and any relevant additional information	Formal Evaluation measures used?	Was the work recorded/observed?	No of sessions	Case complete or ongoing?
1(11.06.19)	Female	Cons Anaes	Pain	Assessment Only	HADS, PSEQ4+2		1	Ongoing
2(11.06.19)	Male	Resp Cons	Coping with diagnosis Mesothelioma	Supportive Counselling	HADS		16	Ongoing
3(12.06.19)	Female	Pharmacist	Poor Diabetes Control	Solution Focused Therapy	HADS		3	Discharged
4(12.06.19)	Male	Pharmacist	Poor Diabetes Control	CBT	HADS		10	Discharged
								

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Trainee Name: Tracy McCrossan Supervisors: Dr Mary Dooher/Dr Rosa Lannon	Placement Type: Health Psychology Placement Dates: 17th January 2019 – 17th January 2021 Date: **Week Commencing 17th June 2019**

Case No.	Demographics (e.g. gender, age, ethnicity)	Referred by	Main Problems	Outline the intervention undertaken, including main treatment modes and any relevant additional information	Formal Evaluation measures used?	Was the work recorded/observed?	No of sessions	Case complete or ongoing?
1(17.06.19)				Trust Wide Psychology Team Day				
2(18.06.19)	Male & Female Group	Cons Anaesthetist	Pain	Review Group	PSEQ4+2 HADS		1	Discharged
3(18.06.19)	Female	Cons Anaes	Pain	Assessment	PSEQ4+2 HADS		1	Ongoing
4(18.06.19)	Male	Cons Anaes	Pain	Assessment	PSEQ4+2 HADS		1	Ongoing
5(18.06.19)	Male	Cons Anaes	Pain	Assessment	PSEQ4+2 HADS		1	Ongoing
6(20.06.19)				Seminar ; Perspectives in Sarcoidosis				

7(20.06.19)				Talk By Jane Ogden at QUB on Obesity				

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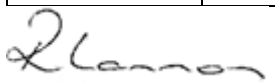
Trainee Name: Tracy McCrossan Supervisors: Dr Mary Dooher/Dr Rosa Lannon	Placement Type: Health Psychology Placement Dates: 17th January 2019 – 17th January 2021 Date: **Week Commencing 24th June 2019**

Case No.	Demographics (e.g. gender, age, ethnicity)	Referred by	Main Problems	Outline the intervention undertaken, including main treatment modes and any relevant additional information	Formal Evaluation measures used?	Was the work recorded/observed?	No of sessions	Case complete or ongoing?
1(24.06.19)	Female	Specialist Nurse	Coping with Ca Diagnosis	Assessment	HADS		1	Ongoing
2(24.06.2019)	Female	Cons Oncologist	Low Mood and insomnia	Solution Focused Therapy	HADS		2	Ongoing
3(24.06.19)				SKYPE meeting with uni supervisors re research				
4(25.06.19)	Male & Female Group	Cons Anaesthetist	Pain	Information Session	PSEQ4+2 HADS		1	
5(25.06.19)	Male	Cons Anaes	Pain	Assessment	PSEQ4+2 HADS		1	Ongoing
6(26.06.19)	Female	GP	Health Anxiety	Supportive Counselling	HADS		5	Ongoing
7(26.06.19)	Male	DSN	Poor Diabetes Control	CBT	HADS		4	Ongoing

8(27.06.19)	Female	Oncologist	Coping with Ca Diagnosis	Solution Focused Therapy	HADS		5	Ongoing
9(27.06.19)	Female	Oncologist	Coping with Ca Diagnosis/Anxiety	Assessment	HADS		1	Ongoing



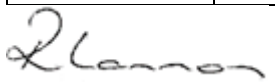
Trainee Name: Tracy McCrossan Supervisors: Dr Mary Dooher/Dr Rosa Lannon	Placement Type: Health Psychology Placement Dates: 17th January 2019 – 17th January 2021 Date: **Week Commencing 1st July 2019**

Case No.	Demographics (e.g. gender, age, ethnicity)	Referred by	Main Problems	Outline the intervention undertaken, including main treatment modes and any relevant additional information	Formal Evaluation measures used?	Was the work recorded/observed?	No of sessions	Case complete or ongoing?
1(01.07.19)	Female	Specialist Nurse	Fear of Ca recurrence/anxiety	Assessment	HADS		1	Ongoing
2(02.07.19)				ADMIN – Ass/Dsc letters				
3(03.02.19)				Supervision with Dr Lannon				
4(04.07.19)	Male	Oncologist	Anxiety	Assessment	HADS		1	Ongoing
5(05.07.19)				Consultancy Contract signed off with Henk Sweigers				

Trainee Name: Tracy McCrossan Supervisors: Dr Mary Dooher/Dr Rosa Lannon	Placement Type: Health Psychology Placement Dates: 17th January 2019 – 17th January 2021 Date: **Week Commencing 8th July 2019**

Case No.	Demographics (e.g. gender, age, ethnicity)	Referred by	Main Problems	Outline the intervention undertaken, including main treatment modes and any relevant additional information	Formal Evaluation measures used?	Was the work recorded/observed?	No of sessions	Case complete or ongoing?
1(08.07.19)	Male	Community Resp Nurse	Acceptance of condition	ACT	HADS		1	Ongoing
2(08.07.19)				Admin Ass/Dsc Letters				
3(09.07.19)	Female	Cons Anaes	Pain	Assessment	PSEQ4+2 HADS		1	Ongoing
4(09.07.19)	Female	Cons Anaesthetist	Pain	Assessment	PSEQ4+2 HADS		1	Ongoing

5(09.07.2019)	Female	Cons Anaes	Pain	Assessment	PSEQ4+2 HADS		1	Ongoing
6(10/11.07.19)				BPS Health Psychology Conference Manchester				



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Trainee Name: Tracy McCrossan Supervisors: Dr Mary Dooher/Dr Rosa Lannon	Placement Type: Health Psychology Placement Dates: 17th January 2019 – 17th January 2021 Date: **Week Commencing 15th July 2019**

Case No.	Demographics (e.g. gender, age, ethnicity)	Referred by	Main Problems	Outline the intervention undertaken, including main treatment modes and any relevant additional information	Formal Evaluation measures used?	Was the work recorded/observed?	No of sessions	Case complete or ongoing?
1(17.07.19)				Supervision with Dr Lannon	HADS			Ongoing
2(17.07.19)	Male	DSN	Poor Diabetes Control	CBT	HADS		5	Ongoing
3(17.07.19)	Female	Specialist Nurse	Fear of Ca recurrence/anxiety	CBT	HADS		2	Ongoing
4(18.07.21)	Female	Oncologist	Anxiety, Ca diagnosis	Solution Focused Therapy	HADS		5	Ongoing
5(18.07.19)	Female	Cons Oncologist	Low mood and insomnia	Solution Focused therapy	HADS		3	Ongoing
6(18.07.19)	Male	Oncologist	Anxiety	Supportive Counselling	HADS		2	Ongoing

7(18.07.19)	Male	Resp Cons	Coping with diagnosis Mesothelioma	Supportive Counselling	HADS		17	

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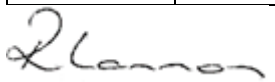
Trainee Name: Tracy McCrossan Supervisors: Dr Mary Dooher/Dr Rosa Lannon	Placement Type: Health Psychology Placement Dates: 17th January 2019 – 17th January 2021 Date: **Week Commencing 22nd July 2019**

Case No.	Demographics (e.g. gender, age, ethnicity)	Referred by	Main Problems	Outline the intervention undertaken, including main treatment modes and any relevant additional information	Formal Evaluation measures used?	Was the work recorded/observed?	No of sessions	Case complete or ongoing?
1(22.07.19)				Query re referral rates for Southern Sector – M Dooher				Ongoing
2(22.07.19)	Female	Specialist Nurse	Coping with Ca Diagnosis	ACT	HADS		2	Ongoing
3(22.07.19)	Female	Oncologist	Coping with Ca diagnosis	Assessment	HADS		1	Ongoing
4(23.07.19)				Pulmonary Rehab group OHPCC (8)	HADS			Ongoing
5(24.07.19)	Female	Cons Anaesthetist	Long term pain	Assessment for PMP	HADS		1	Ongoing
6(24.07.19)	Female	Cons Anaesthetist	Long term pain	Assessment for PMP	HADS		1	Ongoing
7(24.07.19)	Male	Diabetes Nurse	Coping Diabetes	CBT	HADS		3	Complete

8(24.07.19)	Female	GP	Health Anxiety	Supportive Counselling	HADS		5	Ongoing
9(25.07.19)	Female	Specialist nurse	Coping with Ca diagnosis	Assessment	HADS		2	Ongoing



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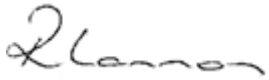
Trainee Name: Tracy McCrossan Supervisors: Dr Mary Dooher/Dr Rosa Lannon	Placement Type: Health Psychology Placement Dates: 17th January 2019 – 17th January 2021 Date: **Week Commencing 29th July 2019**

Case No.	Demographics (e.g. gender, age, ethnicity)	Referred by	Main Problems	Outline the intervention undertaken, including main treatment modes and any relevant additional information	Formal Evaluation measures used?	Was the work recorded/observed?	No of sessions	Case complete or ongoing?
1(29.07.19)				Meet with temp secretary re structuring work				
2(29.07.19)				Meet with PWP re Renal patient				
3(29.07.19)	Female	Oncologist	Coping with Ca diagnosis/anxiety	Supportive Counselling	HADS		2	Ongoing
4(30.07.19)	Male	Long term pain	Cons Anaesthetist	Assessment	HADS		1	Ongoing
5(30.07.19)	Male	Long term Pain	Cons Anaesthetist	Assessment	HADS		1	Ongoing
6(31.07.19)	Female	Specialist Nurse	Fear of Ca recurrence/anxiety	CBT	HADS		3	Ongoing
7(01.08.19)				Consultancy – Pyrography Workshop				



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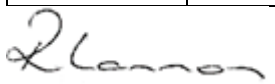
Trainee Name: Tracy McCrossan Supervisors: Dr Mary Dooher/Dr Rosa Lannon	Placement Type: Health Psychology Placement Dates: 17th January 2019 – 17th January 2021 Date: **Week Commencing 5th August 2019**

Case No.	Demographics (e.g. gender, age, ethnicity)	Referred by	Main Problems	Outline the intervention undertaken, including main treatment modes and any relevant additional information	Formal Evaluation measures used?	Was the work recorded/observed?	No of sessions	Case complete or ongoing?
1(05.08.19)	Male	DSN	Adherence	Assessment	HADS		CNA	Ongoing
2(05.08.19)	Female	Oncologist	Coping with Ca diagnosis/anxiety	Supportive Counselling	HADS		2	Ongoing
3(05.08.19)	Female	Oncologist	Coping with Ca diagnosis	Solution Focused Therapy	HADS		6	Ongoing
4(06.08.19)	Female	Cons Anaesthetist	Long term Pain	Assessment	HADS		1	Ongoing
5(06.08.19)	Female	Cons Anaesthetist	Long term pain	Assessment	HADS		1	Ongoing
6(06.08.19)	Female	Cons Anaesthetist	Long term pain	Assessment	HADS		1	Ongoing
7(07.08.19)				Meet with J Gallagher re Diabetes Research				

8(08.08.19)	Female	Cons Oncologist	Low Mood and Insomnia	Solution Focused therapy	HADS		4	Ongoing
9(08.08.19)	Male	Oncologist	Anxiety	Supportive Counselling	HADS		3	Ongoing
10(08.08.19)				Meet with Linda Bahgi re MSc Health Psychology and Prof. Doc Health Psychology)				



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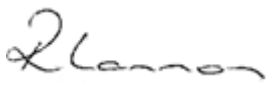
Trainee Name: Tracy McCrossan Supervisors: Dr Mary Dooher/Dr Rosa Lannon	Placement Type: Health Psychology Placement Dates: 17th January 2019 – 17th January 2021 Date: **Week Commencing 12th August 2019**

Case No.	Demographics (e.g. gender, age, ethnicity)	Referred by	Main Problems	Outline the intervention undertaken, including main treatment modes and any relevant additional information	Formal Evaluation measures used?	Was the work recorded/observed?	No of sessions	Case complete or ongoing?
1(12.08.19)	Female	Specialist Nurse	Coping with Ca Diagnosis	ACT	HADS		3	Ongoing
2(13.08.19)	Female	GP	Health Anxiety	Supportive Counselling	HADS		CNA	Ongoing
3(14.08.19)	Female	Resp Cons	Low Mood	Assessment	HADS		1	Ongoing
4(14.08.19)	Male	DSN	Low mood/adherence	Assessment	HADS		1	Ongoing
5(15.08.19)	Female	Specialist Nurse	Coping with Diagnosis	ACT	HADS		3	Ongoing
6(16.08.19)				Verbal attack from temp sec	HADS			Ongoing



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Trainee Name: Tracy McCrossan Supervisors: Dr Mary Dooher/Dr Rosa Lannon	Placement Type: Health Psychology Placement Dates: 17th January 2019 – 17th January 2021 Date: **Week Commencing 19th August 2019**

Case No.	Demographics (e.g. gender, age, ethnicity)	Referred by	Main Problems	Outline the intervention undertaken, including main treatment modes and any relevant additional information	Formal Evaluation measures used?	Was the work recorded/observed?	No of sessions	Case complete or ongoing?
1(19.08.19)	Female	DSN	Coping with lifestyle change	Assessment	HADS		CNC NFA	Ongoing
2(19.08.19)	Female	Oncologist	Coping with Ca diagnosis	Solution Focused Therapy	HADS		7	Ongoing
3(19.08.19)	Female	Oncologist	Coping with Ca diagnosis/anxiety	Supportive Counselling	HADS		3	Ongoing
4(19.08.19)				Supervision M Dooher				
5(20.08.19)	Male	Specialist Nurse	Anxiety	Assessment	HADS		1	Ongoing
6(20.08.19)	Female	Specialist Nurse	Coping	Assessment	HADS		CNC DSC	Ongoing

7(20.08.19)	Male	Resp Cons	Coping with diagnosis Mesothelioma	Supportive Counselling	HADS		18	Ongoing

R Lannon

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Trainee Name: Tracy McCrossan Supervisors: Dr Mary Dooher/Dr Rosa Lannon	Placement Type: Health Psychology Placement Dates: 17th January 2019 – 17th January 2021 Date: **Week Commencing 26th August 2019**

Case No.	Demographics (e.g. gender, age, ethnicity)	Referred by	Main Problems	Outline the intervention undertaken, including main treatment modes and any relevant additional information	Formal Evaluation measures used?	Was the work recorded/observed?	No of sessions	Case complete or ongoing?
				Annual Leave all week				

Trainee Name: Tracy McCrossan Supervisors: Dr Mary Dooher/Dr Rosa Lannon	Placement Type: Health Psychology Placement Dates: 17th January 2019 – 17th January 2021 Date: **Week Commencing 2nd September 2019**

Case No.	Demographics (e.g. gender, age, ethnicity)	Referred by	Main Problems	Outline the intervention undertaken, including main treatment modes and any relevant additional information	Formal Evaluation measures used?	Was the work recorded/observed?	No of sessions	Case complete or ongoing?
				Annual Leave all week				
4.09.19				Diabetes Talk to Diabetes UK Support gp				

R Lannon

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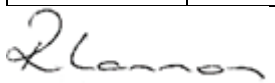
Trainee Name: Tracy McCrossan Supervisors: Dr Mary Dooher/Dr Rosa Lannon	Placement Type: Health Psychology Placement Dates: 17th January 2019 – 17th January 2021 Date: **Week Commencing 9th Sept 2019**

Case No.	Demographics (e.g. gender, age, ethnicity)	Referred by	Main Problems	Outline the intervention undertaken, including main treatment modes and any relevant additional information	Formal Evaluation measures used?	Was the work recorded/observed?	No of sessions	Case complete or ongoing?
1(9.09.19)				Psychology Team Meeting				
2(9.09.19)	Female	Cons Oncologist	Low Mood and Insomnia	Solution Focused therapy	HADS		5	Ongoing
3(9.09.19)	Female	Specialist Nurse	Coping with Ca Diagnosis	ACT	HADS		4	Ongoing
4(10.09.19)	Male and Female gp (13)	Cons Anaesthetist	Long term pain	MDM approach involving psychology, Physiotherapy and Occupational Therapy, delivering a CBT based educational programme to encourage behaviour change and better self-management.	PSEQ4+2 HADS		Session 1 of 8	Ongoing

5(10.09.19)	Male and female group (5)	Cons Anaesthetist	Long term Pain	Information session for PMP			1	Ongoing
6(10.09.19)	Male and female group (7)	Cons Anaesthetist	Long term pain	Review for PMP	PSEQ4+2 HADS		1	Ongoing
7(11.09.19)	Male	DSN	Low mood/adherence	CBT	HADS		2	Ongoing
8(11.09.19)	Female	Resp Cons	Low Mood	Solution Focused therapy	HADS		2	Ongoing
9(11.09.19)	Male	DSN	Poor Diabetes Control	CBT	HADS		6	Ongoing
10(12.09.19)				Presenting at the Psychology or Wellbeing Conference (CNC)				



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Trainee Name: Tracy McCrossan Supervisors: Dr Mary Dooher/Dr Rosa Lannon	Placement Type: Health Psychology Placement Dates: 17th January 2019 – 17th January 2021 Date: **Week Commencing 16th September 2019**

Case No.	Demographics (e.g. gender, age, ethnicity)	Referred by	Main Problems	Outline the intervention undertaken, including main treatment modes and any relevant additional information	Formal Evaluation measures used?	Was the work recorded/observed?	No of sessions	Case complete or ongoing?
1(16.09.19)	Female	Oncologist	Coping with Ca diagnosis/anxiety	Supportive Counselling	HADS		4	Ongoing
2(16.09.19)	Female	Oncologist	Coping with Ca diagnosis	Solution Focused Therapy	HADS		8	Ongoing
3(17.09.19)	Male & Female Group(14)	Cons Anaesthetist	Long Term Pain	MDM approach involving psychology, Physiotherapy and Occupational Therapy, delivering a CBT based educational programme to encourage behaviour change and better self-management.	PSEQ4+2 HADS		Session 2 of 8	Ongoing
4(17.09.19)	Female	Cons Anae	Long term Pain	Assessment for PMP	HADS		1	Ongoing
5(17.09.19)	Female	Cons Anae	Long Term Pain	Assessment for PMP	HADS		1	Ongoing
6(19.08.19)				ACT intermediate level QUB				

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Trainee Name: Tracy McCrossan Supervisors: Dr Mary Dooher/Dr Rosa Lannon	Placement Type: Health Psychology Placement Dates: 17th January 2019 – 17th January 2021 Date: **Week Commencing 23rd Sept 2019**

Case No.	Demographics (e.g. gender, age, ethnicity)	Referred by	Main Problems	Outline the intervention undertaken, including main treatment modes and any relevant additional information	Formal Evaluation measures used?	Was the work recorded/observed?	No of sessions	Case complete or ongoing?
1(23.09.19)	Male	Specialist Nurse	Anxiety	Assessment	HADS		2	Ongoing
2(24.09.19)	Male & Female Group	Cons Anaesthetist	Long Term Pain	MDM approach involving psychology, Physiotherapy and Occupational Therapy, delivering a CBT based educational programme to encourage behaviour change and better self-management.	PSEQ4+2 HADS		Session 3 of 8	Ongoing
3(24.09.19)	Female	Cons Anae	Long Term Pain	Assessment for PMP	HADS		1	Ongoing
4(24.09.19)	Female	Cons Anae	Long Term Pain	Assessment for PMP	HADS		1	Ongoing
5(25.09.19)				Capacity Training				

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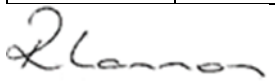
Trainee Name: Tracy McCrossan Supervisors: Dr Mary Dooher/Dr Rosa Lannon	Placement Type: Health Psychology Placement Dates: 17th January 2019 – 17th January 2021 Date: **Week Commencing 30th September 2019**

Case No.	Demographics (e.g. gender, age, ethnicity)	Referred by	Main Problems	Outline the intervention undertaken, including main treatment modes and any relevant additional information	Formal Evaluation measures used?	Was the work recorded/observed?	No of sessions	Case complete or ongoing?
1(30.09.19)	Female	Oncologist	Coping with Ca diagnosis	Solution Focused Therapy	HADS		8	Ongoing
2(30.09.19)	Male	Resp Cons	Anxiety/panic	Assessment	HADS		1	Ongoing
3(01.10.19)	Male & Female Group	Cons Anaesthetist	Long Term Pain	MDM approach involving psychology, Physiotherapy and Occupational Therapy, delivering a CBT based educational programme to encourage behaviour change and better self-management.	PSEQ4+2 HADS		Session 4 of 8	Ongoing
4(01.10.19)				PMP Team Meeting				
5(02.10.19)	Female	Specialist Nurse	Fear of Ca recurrence/anxiety	CBT	HADS		4	Ongoing

6(02.10.19)	Male	DSN	Low mood/adherence	CBT	HADS		3	Ongoing
7(02.10.19)	Female	Specialist Nurse	Coping with dialysis	Assessment	HADS		1	Ongoing
8(02.10.19)	Group of male and female (7)	Resp Cons	Chronic Respiratory condition	Group Input – low mood			1	
9(03.10.19)				Skype meeting with Rachel and Helen				



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Trainee Name: Tracy McCrossan Supervisors: Dr Mary Dooher/Dr Rosa Lannon	Placement Type: Health Psychology Placement Dates: 17th January 2019 – 17th January 2021 Date: **Week Commencing 7th October 2019**

Case No.	Demographics (e.g. gender, age, ethnicity)	Referred by	Main Problems	Outline the intervention undertaken, including main treatment modes and any relevant additional information	Formal Evaluation measures used?	Was the work recorded/observed?	No of sessions	Case complete or ongoing?
1(07.10.19)	Male	Specialist Nurse	Anxiety	Assessment	HADS		3	Ongoing
2(07.10.19)	Female	Specialist Nurse	Coping with Ca Diagnosis	ACT	HADS		5	
3(07.10.19)	Male	Oncologist	Anxiety	Supportive Counselling	HADS		4	
4(08.10.19)	Male & Female Group	Cons Anaesthetist	Long term pain	MDM approach involving psychology, Physiotherapy and Occupational Therapy, delivering a CBT based educational programme to encourage behaviour change and better self-management.	PSEQ4+2 HADS		Session 5 of 8	Ongoing
5(08.10.19)	Female	Cons Anaesthetist	Long term pain	PMP Assessment	HADS		1	Ongoing

6(08.10.19)	Male	Cons Anaesthetist	Long term pain	PMP assessment	HADS		1	Ongoing
7(09.10.19)	Female	DSN	Low mood	Assessment	HADS		1	Ongoing
8(09.10.19)	Male	Specialist nurse	Adjustment	Assessment	HADS		1	Ongoing
9(09.10.19)	Female	DSN	Adherence	Assessment	HADS		1	Ongoing
10(09.10.20)	Male	DSN	Needle Phobia	Assessment	HADS		1	Ongoing

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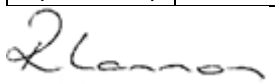
Trainee Name: Tracy McCrossan Supervisors: Dr Mary Dooher/Dr Rosa Lannon	Placement Type: Health Psychology Placement Dates: 17th January 2019 – 17th January 2021 Date: **Week Commencing 14th October 2019**

Case No.	Demographics (e.g. gender, age, ethnicity)	Referred by	Main Problems	Outline the intervention undertaken, including main treatment modes and any relevant additional information	Formal Evaluation measures used?	Was the work recorded/observed?	No of sessions	Case complete or ongoing?
1(14.10.19)	Female	Oncologist	Coping with Ca diagnosis	Solution Focused Therapy	HADS		9	Ongoing
2(14.10.19)	Female	Oncologist	Coping with Ca diagnosis/anxiety	Supportive Counselling	HADS		5	Ongoing
3(14.10.19)	Male	Resp Cons	Anxiety/panic	CBT	HADS		2	Ongoing
4(15.10.19)	Male & Female Group	Cons Anaesthetist	Long Term Pain	MDM approach involving psychology, Physiotherapy and Occupational Therapy, delivering a CBT based educational programme to encourage behaviour change and better self-management.	PSEQ4+2 HADS		Session 6 of 8	Ongoing
5(15.10.19)				Assistant/Associate Psychologist Forum				

6(16.10.19)	Female	Resp Cons	Low mood	Assessment	HADS		1	Ongoing
7(16.10.19)	Male	Specialist nurse	Adjustment	Assessment2	HADS		2	Ongoing
8(16.10.19)				Pulmonary Rehab (Anxiety)				



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Trainee Name: Tracy McCrossan Supervisors: Dr Mary Dooher/Dr Rosa Lannon	Placement Type: Health Psychology Placement Dates: 17th January 2019 – 17th January 2021 Date: **Week Commencing 21st October 2019**

Case No.	Demographics (e.g. gender, age, ethnicity)	Referred by	Main Problems	Outline the intervention undertaken, including main treatment modes and any relevant additional information	Formal Evaluation measures used?	Was the work recorded/observed?	No of sessions	Case complete or ongoing?
1(21.10.19)	Male	Specialist Nurse	Anxiety	CBT	HADS		4	Ongoing
2(21.10.19)	Female	Specialist Nurse	Coping with Ca Diagnosis	ACT	HADS		6	
3(21.10.19)	Male	Oncologist	Anxiety	Supportive Counselling	HADS		5	
4(21.10.19)	Male	DSN	Low mood	Assessment	HADS		1	Ongoing
5(22.10.19)	Male & Female Group	Cons Anaesthetist	Long Term Pain	MDM approach involving psychology, Physiotherapy and Occupational Therapy, delivering a CBT based educational programme to encourage behaviour change and better self-management.	PSEQ4+2 HADS		Session 27of 8	Ongoing

R Lannon

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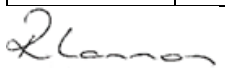
Trainee Name: Tracy McCrossan Supervisors: Dr Mary Dooher/Dr Rosa Lannon	Placement Type: Health Psychology Placement Dates: 17th January 2019 – 17th January 2021 Date: **Week Commencing 28th October 2019**

Case No.	Demographics (e.g. gender, age, ethnicity)	Referred by	Main Problems	Outline the intervention undertaken, including main treatment modes and any relevant additional information	Formal Evaluation measures used?	Was the work recorded/observed?	No of sessions	Case complete or ongoing?
1(28.10.19)	Female	Oncologist	Coping with Ca diagnosis/anxiety	Supportive Counselling	HADS		6	Ongoing
2(28.10.19)	Male	Resp Cons	Anxiety/panic	CBT	HADS		3	Ongoing
3(29.10.19)	Male & Female Group	Cons Anaesthetist	Long Term Pain	MDM approach involving psychology, Physiotherapy and Occupational Therapy, delivering a CBT based educational programme to encourage behaviour change and better self-management.	PSEQ4+2 HADS		Session 8 of 8	Complete
4(29.10.19)	Male	DSN	Needle Phobia	Hypnotherapy	HADS		1	Ongoing



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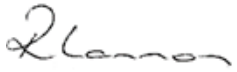
Trainee Name: Tracy McCrossan Supervisors: Dr Mary Dooher/Dr Rosa Lannon	Placement Type: Health Psychology Placement Dates: 17th January 2019 – 17th January 2021 Date: **Week Commencing 4th November 2019**

Case No.	Demographics (e.g. gender, age, ethnicity)	Referred by	Main Problems	Outline the intervention undertaken, including main treatment modes and any relevant additional information	Formal Evaluation measures used?	Was the work recorded/observed?	No of sessions	Case complete or ongoing?
1(04.11.19)				Psychology Team Meeting				
2(04.11.19)	Female	Oncologist	Coping with Ca diagnosis	Solution Focused Therapy	HADS		10	Ongoing
3(04.11.19)	Male	Specialist Nurse	Anxiety	CBT	HADS		5	Ongoing
4(05.11.19)				PMP Info Session			1	
5(05.11.19)				Supervision with Dr Lannon				
6(06.11.19)	Female	Specialist Nurse	Fear of Ca recurrence/anxiety	CBT	HADS		5	Ongoing
7(06.11.19)	Female	DSN	Adherence	Assessment	HADS		2	
8(06.11.19)	Female	Specialist Nurse	Coping with dialysis	Assessment	HADS		2	



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Trainee Name: Tracy McCrossan Supervisors: Dr Mary Dooher/Dr Rosa Lannon	Placement Type: Health Psychology Placement Dates: 17th January 2019 – 17th January 2021 Date: **Week Commencing 11th November 2019**

Case No.	Demographics (e.g. gender, age, ethnicity)	Referred by	Main Problems	Outline the intervention undertaken, including main treatment modes and any relevant additional information	Formal Evaluation measures used?	Was the work recorded/observed?	No of sessions	Case complete or ongoing?
1(11.11.19)				SS Psychology Team Meeting				
2(11.11.19)	Male	Resp Cons	Anxiety/panic	CBT	HADS		4	Ongoing
3(11.11.19)	Male	Oncologist	Anxiety	Supportive Counselling	HADS		6	Ongoing
4(13.11.19)	Male	Specialist nurse	Adjustment	CBT	HADS		3	Ongoing
5(13.11.19)	Female	DSN	Adherence	COM-B/CBT	HADS		3	Ongoing
6(13.11.19)	Female	Specialist Nurse	Coping with dialysis	Supportive Counselling	HADS		3	Ongoing

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Trainee Name: Tracy McCrossan Supervisors: Dr Mary Dooher/Dr Rosa Lannon	Placement Type: Health Psychology Placement Dates: 17th January 2019 – 17th January 2021 Date: **Week Commencing 18th Nov 2019**

Case No.	Demographics (e.g. gender, age, ethnicity)	Referred by	Main Problems	Outline the intervention undertaken, including main treatment modes and any relevant additional information	Formal Evaluation measures used?	Was the work recorded/observed?	No of sessions	Case complete or ongoing?
1(18.11.19)	Female	Oncologist	Coping with Ca diagnosis	Solution Focused Therapy	HADS		11	Ongoing
2(18.11.19)	Male	Specialist Nurse	Anxiety	CBT	HADS		6	Ongoing
3(20.11.19)	Female	Resp Physio	Anxiety	Assessment	HADS		1	Ongoing

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Trainee Name: Tracy McCrossan Supervisors: Dr Mary Dooher/Dr Rosa Lannon	Placement Type: Health Psychology Placement Dates: 17th January 2019 – 17th January 2021 Date: **Week Commencing 25th Nov 2019**

Case No.	Demographics (e.g. gender, age, ethnicity)	Referred by	Main Problems	Outline the intervention undertaken, including main treatment modes and any relevant additional information	Formal Evaluation measures used?	Was the work recorded/observed?	No of sessions	Case complete or ongoing?
1(25.11.19)	Male	Resp Cons	Anxiety/panic	CBT	HADS		5	Ongoing
2(25.11.19)				Tel Call re patient to comm resp nurse				Ongoing
3(26.11.19)				PMP Talks – Revision and planning				
4(27.11.19)	Female	DSN	Low mood	Psycho-education	HADS		2	Ongoing
5(27.11.19)	Female	DSN	Adherence	COM-B/CBT	HADS		4	Ongoing
6(28.11.19)	Female	Oncologist	Coping with Ca diagnosis/anxiety	Supportive Counselling	HADS		7	Ongoing

R Lannon

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Trainee Name: Tracy McCrossan Supervisors: Dr Mary Dooher/Dr Rosa Lannon	Placement Type: Health Psychology Placement Dates: 17th January 2019 – 17th January 2021 Date: **Week Commencing 2nd Dec 2019**

Case No.	Demographics (e.g. gender, age, ethnicity)	Referred by	Main Problems	Outline the intervention undertaken, including main treatment modes and any relevant additional information	Formal Evaluation measures used?	Was the work recorded/observed?	No of sessions	Case complete or ongoing?
1(2.12.19)	Male	Specialist Nurse	Anxiety	CBT	HADS		7	Ongoing
2(03.12.19)				Supervision with Dr Lannon				
3(03.12.19)	Male and Female group	Cons Anaesthetist	Long term pain	PMP information session			1	
4(04.12.19)				Psychology Team Meeting				
5(04.12.20)	Male	DSN	Needle Phobia	Hypnotherapy	HADS		3	Ongoing

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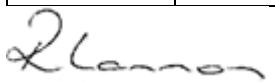
Trainee Name: Tracy McCrossan Supervisors: Dr Mary Dooher/Dr Rosa Lannon	Placement Type: Health Psychology Placement Dates: 17th January 2019 – 17th January 2021 Date: **Week Commencing 9th December 2019**

Case No.	Demographics (e.g. gender, age, ethnicity)	Referred by	Main Problems	Outline the intervention undertaken, including main treatment modes and any relevant additional information	Formal Evaluation measures used?	Was the work recorded/observed?	No of sessions	Case complete or ongoing?
1(09.12.19)				Psychology Away Day (Wider Psych team)				
2(10.12.19)	Group male and female	Cons anaesthetist	Long term pain	Review group				
3(11.12.19)	Female	Resp Physio	Anxiety	Psycho-education	HADS		2	Ongoing
4(11.12.19)	Female	Specialist Nurse	Coping with dialysis	Supportive Counselling	HADS		4	Ongoing



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Trainee Name: Tracy McCrossan Supervisors: Dr Mary Dooher/Dr Rosa Lannon	Placement Type: Health Psychology Placement Dates: 17th January 2019 – 17th January 2021 Date: **Week Commencing 16th December 2019**

Case No.	Demographics (e.g. gender, age, ethnicity)	Referred by	Main Problems	Outline the intervention undertaken, including main treatment modes and any relevant additional information	Formal Evaluation measures used?	Was the work recorded/observed?	No of sessions	Case complete or ongoing?
1(16.12.19)	Male	Specialist Nurse	Anxiety	CBT	HADS		8	Ongoing
2(17.12.19)	Female	Oncologist	Coping with Ca diagnosis	Solution Focused Therapy	HADS		12	Ongoing
3(17.11.19)				Admin Meeting				

R Lannon

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Trainee Name: Tracy McCrossan Supervisors: Dr Mary Dooher/Dr Rosa Lannon	Placement Type: Health Psychology Placement Dates: 17th January 2019 – 17th January 2021 Date: **Week Commencing 23rd December 2019**

Case No.	Demographics (e.g. gender, age, ethnicity)	Referred by	Main Problems	Outline the intervention undertaken, including main treatment modes and any relevant additional information	Formal Evaluation measures used?	Was the work recorded/observed?	No of sessions	Case complete or ongoing?
23.12.19				Annual Leave				Ongoing

R Lannon

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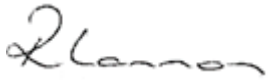
Trainee Name: Tracy McCrossan Supervisors: Dr Mary Dooher/Dr Rosa Lannon	Placement Type: Health Psychology Placement Dates: 17th January 2019 – 17th January 2021 Date: **Week Commencing 30th Dec 2019**

Case No.	Demographics (e.g. gender, age, ethnicity)	Referred by	Main Problems	Outline the intervention undertaken, including main treatment modes and any relevant additional information	Formal Evaluation measures used?	Was the work recorded/observed?	No of sessions	Case complete or ongoing?
30.12.19				Annual Leave	HADS			Ongoing

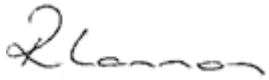
Trainee Name: Tracy McCrossan Supervisors: Dr Mary Dooher/Dr Rosa Lannon	Placement Type: Health Psychology Placement Dates: 17th January 2019 – 17th January 2021 Date: **Week Commencing 6th Jan 2020**

Case No.	Demographics (e.g. gender, age, ethnicity)	Referred by	Main Problems	Outline the intervention undertaken, including main treatment modes and any relevant additional information	Formal Evaluation measures used?	Was the work recorded/observed?	No of sessions	Case complete or ongoing?
1(06.01.20)	Male	Specialist Nurse	Anxiety	CBT	HADS		9	Ongoing
2(06.01.20)				Supervision with Dr Lannon				
3(07.01.20)	Male and female group	Cons Anaes	Long term pain	PMP info session			1	
4(08.01.20)				Meeting Dr Gallagher re respiratory pathway				
5(08.01.20)				Meeting Dr Gallagher re diabetes research				
6(09.01.20)	Female	Renal Cons	Anxiety	Assessment	HADS		1	Complete
7(09.01.20)	Female	Oncologist	Coping with Ca diagnosis	Solution Focused Therapy	HADS		13	Ongoing



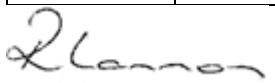
Trainee Name: Tracy McCrossan Supervisors: Dr Mary Dooher/Dr Rosa Lannon	Placement Type: Health Psychology Placement Dates: 17th January 2019 – 17th January 2021 Date: **Week Commencing 13th Jan 2020**

Case No.	Demographics (e.g. gender, age, ethnicity)	Referred by	Main Problems	Outline the intervention undertaken, including main treatment modes and any relevant additional information	Formal Evaluation measures used?	Was the work recorded/observed?	No of sessions	Case complete or ongoing?
1(13.01.20)	Male	Oncologist	Anxiety	Supportive Counselling	HADS		7	Ongoing
2(14.01.20)	Male and female group	Cons Anaes	Long term pain	PMP info session			1	
3(15.01.20)	Female	Resp Physio	Anxiety	Psycho-education	HADS		3	Ongoing
4(15.01.20)	Male	Oncologist	Anxiety	Assessment	HADS		1	Ongoing
5(15.01.20)	Male	DSN	Low mood/adherence	Assessment	HADS		1	Ongoing
6(15.01.20)	Female	DSN	Adherence	COM-B/CBT	HADS		5	Complete
7(16.01.20)	Male	Specialist Nurse	Anxiety	CBT	HADS		10	Ongoing
8(16.01.20)	Female	Oncologist	Coping with Ca diagnosis/anxiety	Supportive Counselling	HADS		8	Ongoing
9(16.01.21)	Male	DSN	Needle Phobia	Hypnotherapy	HADS		4	Ongoing



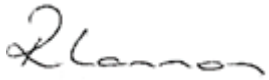
Trainee Name: Tracy McCrossan Supervisors: Dr Mary Dooher/Dr Rosa Lannon	Placement Type: Health Psychology Placement Dates: 17th January 2019 – 17th January 2021 Date: **Week Commencing 20th Jan 2020**

Case No.	Demographics (e.g. gender, age, ethnicity)	Referred by	Main Problems	Outline the intervention undertaken, including main treatment modes and any relevant additional information	Formal Evaluation measures used?	Was the work recorded/observed?	No of sessions	Case complete or ongoing?
1(20.01.20)				Annual Leave/Study Week				



Trainee Name: Tracy McCrossan Supervisors: Dr Mary Dooher/Dr Rosa Lannon	Placement Type: Health Psychology Placement Dates: 17th January 2019 – 17th January 2021 Date: **Week Commencing 27th Jan 2020**

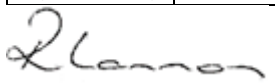
Case No.	Demographics (e.g. gender, age, ethnicity)	Referred by	Main Problems	Outline the intervention undertaken, including main treatment modes and any relevant additional information	Formal Evaluation measures used?	Was the work recorded/observed?	No of sessions	Case complete or ongoing?
1(27.01.20)	Female	Oncologist	Coping with Ca diagnosis	Solution Focused Therapy	HADS		14	Ongoing
2(27.01.20)	Male	Resp Cons	Anxiety/panic	CBT	HADS		6	Ongoing
3(27.01.20)	Female	Oncologist	Anxiety	Assessment	HADS		1	Ongoing
4(28.01.20)		Cons Anae	Long term pain	Assessment PMP	HADS		1	Ongoing
5(28.01.20)		Cons Anae	Long term pain	Assessment PMP	HADS		1	Ongoing
6(28.01.20)		Cons Anae	Long term pain	Assessment PMP	HADS		1	Ongoing
7(28.01.20)	Group mixed	Cons Anae	Long term pain	Information Session			1	
8(29.01.20)				Health Psychology in PMP talk to physios SWAH				
9(29.01.20)	Female	DSN	Adherence	Assessment	HADS		1	Complete
10(29.01.20)				Pul Rehab OHPCC (Low mood)				



Trainee Name: Tracy McCrossan Supervisors: Dr Mary Dooher/Dr Rosa Lannon	Placement Type: Health Psychology Placement Dates: 17th January 2019 – 17th January 2021 Date: **Week Commencing 3rd February 2020**

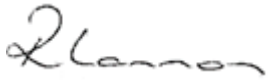
Case No.	Demographics (e.g. gender, age, ethnicity)	Referred by	Main Problems	Outline the intervention undertaken, including main treatment modes and any relevant additional information	Formal Evaluation measures used?	Was the work recorded/observed?	No of sessions	Case complete or ongoing?
1(03.02.20)	Male	Specialist Nurse	Anxiety	CBT	HADS		11	Ongoing
2(03.02.20)	Male	Oncologist	Anxiety	Supportive Counselling	HADS		8	Ongoing
3(03.02.20)	Male	Clinical Psychologist	Needle Phobia	Hypnotherapy/CBT/Supportive Counselling	HADS		49	Complete
4(04.02.20)	Male and Female group x 12	Cons Anaes	Long term pain	MDT approach involving psychology, physiotherapy and occupational therapy delivering a CBT based educational programme to encourage behaviour change and better self management.	PSEQ4+2 HADS		1 of 8	Ongoing
5(04.02.20)	Male and female group	Resp Cons		Pulmonary rehab (low mood)	HADS		1	Ongoing

6(05.02.20)	Female	Resp Physio	Anxiety	Psycho-education	HADS		4	Ongoing
7(05.02.20)	Male	Oncologist	Anxiety	Assessment	HADS		2	Ongoing



Trainee Name: Tracy McCrossan Supervisors: Dr Mary Dooher/Dr Rosa Lannon	Placement Type: Health Psychology Placement Dates: 17th January 2019 – 17th January 2021 Date: **Week Commencing 10th Feb 2020**

Case No.	Demographics (e.g. gender, age, ethnicity)	Referred by	Main Problems	Outline the intervention undertaken, including main treatment modes and any relevant additional information	Formal Evaluation measures used?	Was the work recorded/observed?	No of sessions	Case complete or ongoing?
1(10.02.20)	Female	Oncologist	Anxiety	CBT	HADS		2	Ongoing
2(11.02.20)	Male and Female group x 12	Cons Anaes	Long term pain	MDT approach involving psychology, physiotherapy and occupational therapy delivering a CBT based educational programme to encourage behaviour change and better self management.	PSEQ4+2 HADS		2 of 8	Ongoing
3(12.02.20)				Pain Management Team meeting				
4(13.02.20)	Female	Oncologist	Coping with Ca diagnosis	Solution Focused Therapy	HADS		15	Ongoing
5(13.02.20)	Male	Resp Cons	Anxiety/panic	CBT	HADS		7	Ongoing
					HADS			Ongoing



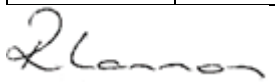
Trainee Name: Tracy McCrossan Supervisors: Dr Mary Dooher/Dr Rosa Lannon	Placement Type: Health Psychology Placement Dates: 17th January 2019 – 17th January 2021 Date: **Week Commencing 17th February 2020**

Case No.	Demographics (e.g. gender, age, ethnicity)	Referred by	Main Problems	Outline the intervention undertaken, including main treatment modes and any relevant additional information	Formal Evaluation measures used?	Was the work recorded/observed?	No of sessions	Case complete or ongoing?
1(17.02.20)				Annual Leave				

Trainee Name: Tracy McCrossan Supervisors: Dr Mary Dooher/Dr Rosa Lannon	Placement Type: Health Psychology Placement Dates: 17th January 2019 – 17th January 2021 Date: **Week Commencing 24th February 2020**

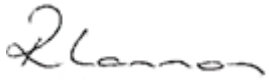
Case No.	Demographics (e.g. gender, age, ethnicity)	Referred by	Main Problems	Outline the intervention undertaken, including main treatment modes and any relevant additional information	Formal Evaluation measures used?	Was the work recorded/observed?	No of sessions	Case complete or ongoing?
1(24.02.20)	Male	Specialist Nurse	Anxiety	CBT	HADS		12	Ongoing
2(24.02.20)	Male	Oncologist	Anxiety	Supportive Counselling	HADS		9	Ongoing
3(24.02.20)	Female	Oncologist	Coping with Ca diagnosis/anxiety	Supportive Counselling	HADS		9	Ongoing
4(24.02.20)	Female	Resp Cons	Coping	Assessment	HADS		1	Ongoing
5(25.02.20)	Male and Female group x 12	Cons Anaes	Long term pain	MDT approach involving psychology, physiotherapy and occupational therapy delivering a CBT based educational programme to encourage behaviour change and better self management.	PSEQ4+2 HADS		3 of 8	Ongoing
6(25.02.20)				Appraisal with Dr Dooher				

7(25.02.20)	Male and female group	Cons Anaes	Long term pain	PMP review group			1	
8(26.02.20)	Female	Clinical Psychologist	Hypoglycaemia recognition	Assessment	HADS		1	Ongoing



Trainee Name: Tracy McCrossan Supervisors: Dr Mary Dooher/Dr Rosa Lannon	Placement Type: Health Psychology Placement Dates: 17th January 2019 – 17th January 2021 Date: **Week Commencing 2nd March 2020**

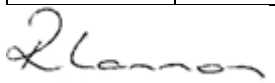
Case No.	Demographics (e.g. gender, age, ethnicity)	Referred by	Main Problems	Outline the intervention undertaken, including main treatment modes and any relevant additional information	Formal Evaluation measures used?	Was the work recorded/observed?	No of sessions	Case complete or ongoing?
1(02.03.20)	Female	Oncologist	Coping with Ca diagnosis	Solution Focused Therapy	HADS		16	Ongoing
2(02.03.20)	Female	Oncologist	Anxiety	CBT	HADS		3	Ongoing
3(03.03.20)	Male and Female group x 10	Cons Anaes	Long term pain	MDT approach involving psychology, physiotherapy and occupational therapy delivering a CBT based educational programme to encourage behaviour change and better self management.	PSEQ4+2 HADS		4 of 8	Ongoing
4(03.03.20)	Female	Cons Anaes	Coping with Pain	Assessment	HADS		1	Ongoing
5(04.03.20)				PMP supervision				



Trainee Name: Tracy McCrossan Supervisors: Dr Mary Dooher/Dr Rosa Lannon	Placement Type: Health Psychology Placement Dates: 17th January 2019 – 17th January 2021 Date: **Week Commencing 9th March 2020**

Case No.	Demographics (e.g. gender, age, ethnicity)	Referred by	Main Problems	Outline the intervention undertaken, including main treatment modes and any relevant additional information	Formal Evaluation measures used?	Was the work recorded/observed?	No of sessions	Case complete or ongoing?
1(09.03.20)	Male	Specialist Nurse	Anxiety	CBT	HADS		12	Ongoing
2(09.03.20)	Female	Oncologist	Coping with Ca diagnosis/anxiety	Supportive Counselling	HADS		9	Ongoing
3(09.03.20)	Female	Resp Cons	Coping	CBT	HADS		2	Ongoing
4(10.02.20)	Male and Female group x 10	Cons Anaes	Long term pain	MDT approach involving psychology, physiotherapy and occupational therapy delivering a CBT based educational programme to encourage behaviour change and better self management.	PSEQ4+2 HADS		5 of 8	Ongoing
5(10.02.20)				Health Psychology in PMP for GP's				

6(11.02.20)	Female	Clinical Psychologist	Hypoglycaemia recognition	CBT	HADS		2	



Trainee Name: Tracy McCrossan Supervisors: Dr Mary Dooher/Dr Rosa Lannon	Placement Type: Health Psychology Placement Dates: 17th January 2019 – 17th January 2021 Date: **Week Commencing 16th March 2020**

All clinics cancelled this week as a result of COVID 19. Lots of research done looking at previous psychological response to pandemic situations, SARS etc. Possibility of helpline being set up etc. Stress++

Trainee Name: Tracy McCrossan Supervisors: Dr Mary Dooher/Dr Rosa Lannon	Placement Type: Health Psychology Placement Dates: 17th January 2019 – 17th January 2021 Date: **Week Commencing 23rd March 2020**

Clinics remain cancelled. Setting up protocols for working remotely, telephone contact/virtual contact, exploring confidentiality, informed consent etc

Trainee Name: Tracy McCrossan Supervisors: Dr Mary Dooher/Dr Rosa Lannon	Placement Type: Health Psychology Placement Dates: 17th January 2019 – 17th January 2021 Date: **Week Commencing 30th March 2020**

Clinics still remain cancelled as trust guidance has been that all resources need to be redirected to acute wards and all other outpatient activity to cease for now.

A mix of working from home and in office.

Helpline for staff has been established and psychology staff manning it on a shift basis from 9am-10pm x 7 days per week.

2.04.20: Zoom Meeting with Dr Helen Poole

5.04.20: Working on Helpline 1pm 5pm

Trainee Name: Tracy McCrossan Supervisors: Dr Mary Dooher/Dr Rosa Lannon	Placement Type: Health Psychology Placement Dates: 17th January 2019 – 17th January 2021 Date: **Week Commencing 6th April 2020**

Case No.	Demographics (e.g. gender, age, ethnicity)	Referred by	Main Problems	Outline the intervention undertaken, including main treatment modes and any relevant additional information	Formal Evaluation measures used?	Was the work recorded/observed?	No of sessions	Case complete or ongoing?
1(07.04.20)				Psychology Team meeting via zoom				
2(07.04.20)				Supervision with Dr Lannon				
3(08.04.20)	Female	Cons Diabetologist	Coping with condition	Tele Assessment	HADS		1	Ongoing
4(08.04.20)				Working on helpline 5pm – 9pm				
5(10.04.20)				Working on helpline 5pm – 9pm				
					HADS			Ongoing

Trainee Name: Tracy McCrossan Supervisors: Dr Mary Dooher/Dr Rosa Lannon	Placement Type: Health Psychology Placement Dates: 17th January 2019 – 17th January 2021 Date: **Week Commencing 12th April 2020**

Case No.	Demographics (e.g. gender, age, ethnicity)	Referred by	Main Problems	Outline the intervention undertaken, including main treatment modes and any relevant additional information	Formal Evaluation measures used?	Was the work recorded/observed?	No of sessions	Case complete or ongoing?
1(12.04.20)				Working on helpline 9-5pm				
2(13.04.20)				Working on helpline 5-10pm				
3(16.04.20)				Mid placement review with Helen & Mary via Zoom				
4(17.04.20)				Conference call with diabetes team re research				
5(17.04.20)				Working on helpline				
6(17.04.21)	Male	DSN	Needle Phobia	Hypnotherapy review	HADS		1	Complete

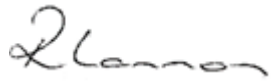
R Lannon

Trainee Name: Tracy McCrossan Supervisors: Dr Mary Dooher/Dr Rosa Lannon	Placement Type: Health Psychology Placement Dates: 17th January 2019 – 17th January 2021 Date: **Week Commencing 20th April 2020**

All tele/virtual contacts

Case No.	Demographics (e.g. gender, age, ethnicity)	Referred by	Main Problems	Outline the intervention undertaken, including main treatment modes and any relevant additional information	Formal Evaluation measures used?	Was the work recorded/observed?	No of sessions	Case complete or ongoing?
1(20.04.20)				Working on helpline 5-10am				
2(21.04.20)	Male and female group	Cons Anaes	Coping chronic pain	Tele appts with all patient who were in the middle of PMP				Ongoing
3(21.04.20)	Female	Comm Resp Nurse	Anxiety	Assessment	HADS		1	Ongoing
4(21.04.20)	Male	DSN	Adherence	Assessment	HADS		1	Ongoing
5(22.04.20)	Female	Resp Physio	Anxiety	CBT	HADS		5	Complete
6(22.04.20)	Male	Oncologist	Anxiety	Solution focused therapy	HADS		3	Ongoing

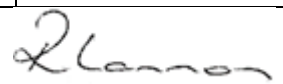
7(22.04.20)	Female	Clinical Psychologist	Hypoglycaemia recognition	CBT	HADS		3	Ongoing
8(23.04.20)	Male	Specialist Nurse	Anxiety	CBT	HADS		13	Ongoing
9(23.04.20)	Female	Oncologist	Coping with Ca diagnosis/anxiety	Supportive Counselling	HADS		10	Ongoing
10(23.04.20)	Male	Resp Cons	Anxiety/panic	CBT	HADS		8	Ongoing
11(23.04.20)	Female	Resp Nurse	Anxiety	Assessment	HADS		1	Ongoing
12(24.04.20)				Webinar – getting to grips with endnote				



Trainee Name: Tracy McCrossan Supervisors: Dr Mary Dooher/Dr Rosa Lannon	Placement Type: Health Psychology Placement Dates: 17th January 2019 – 17th January 2021 Date: **Week Commencing 26th April 2020**

Case No.	Demographics (e.g. gender, age, ethnicity)	Referred by	Main Problems	Outline the intervention undertaken, including main treatment modes and any relevant additional information	Formal Evaluation measures used?	Was the work recorded/observed?	No of sessions	Case complete or ongoing?
1(26.04.20)				Working on helpline 9-1pm				
2(27.04.20)	Female	Oncologist	Anxiety	CBT	HADS		4	Ongoing
3(27.04.20)	Female	DSN	Anxiety & low mood	Assessment	HADS		1	Ongoing
4(27.04.20)	Female	Resp Cons	Coping	CBT	HADS		3	Ongoing
5(27.04.20)	Male	Oncologist	Anxiety	Supportive Counselling	HADS		10	Ongoing
6(28.04.20)	Male and female group	Cons Aneas	Long term Pain	PMP reviews via tele link	HADS		1	Complete
7(28.04.20)	Female	Comm Resp Nurse	Anxiety	Assessment	HADS		2	Ongoing
8(28.04.20)	Female	Oncologist	Coping with Ca diagnosis/anxiety	Supportive Counselling	HADS		10	Complete
9(29.04.20)	Female	DSN	Adherence	Assessment	HADS		1	Ongoing

10(29.04.20)	Female	DSN	Coping	Assessment	HADS		1	Ongoing



Trainee Name: Tracy McCrossan Supervisors: Dr Mary Dooher/Dr Rosa Lannon	Placement Type: Health Psychology Placement Dates: 17th January 2019 – 17th January 2021 Date: **Week Commencing 4th May 2020**

Case No.	Demographics (e.g. gender, age, ethnicity)	Referred by	Main Problems	Outline the intervention undertaken, including main treatment modes and any relevant additional information	Formal Evaluation measures used?	Was the work recorded/observed?	No of sessions	Case complete or ongoing?
1(05.05.20)				Supervision with Dr Lannon				
2(05.05.20)				HEE Behaviour Change development framework and toolkit webinar				
3(06.05.20)	Male	Oncologist	Anxiety	Solution focused therapy	HADS		4	Ongoing
4(06.05.20)	Female	Clinical Psychologist	Hypoglycaemia recognition	CBT	HADS		4	Ongoing
5(07.05.20)	Male	Specialist Nurse	Anxiety	CBT	HADS		13	Complete
6(07.05.20)	Male	Resp Cons	Anxiety/panic	CBT	HADS		9	Ongoing
7(07.05.20)	Female	Resp Nurse	Anxiety	Assessment	HADS		2	Ongoing

R Lannon

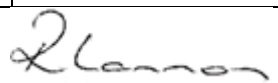
Trainee Name: Tracy McCrossan Supervisors: Dr Mary Dooher/Dr Rosa Lannon	Placement Type: Health Psychology Placement Dates: 17th January 2019 – 17th January 2021 Date: **Week Commencing 11th May 2020**

Case No.	Demographics (e.g. gender, age, ethnicity)	Referred by	Main Problems	Outline the intervention undertaken, including main treatment modes and any relevant additional information	Formal Evaluation measures used?	Was the work recorded/observed?	No of sessions	Case complete or ongoing?
1(11.05.20)	Female	Resp Cons	Coping	CBT	HADS		4	Ongoing
2(11.05.20)	Male	Oncologist	Anxiety	Supportive Counselling	HADS		11	Complete
3(12.05.20)				Webinar: Open Science for health Psychology				
4(12.05.20)	Female	Comm Resp Nurse	Anxiety	CBT	HADS		3	Ongoing
5(13.05.20)	Female	DSN	Adherence	CBT	HADS		2	Ongoing
6(13.05.20)	Female	DSN	Coping	Solution Focused Therapy	HADS		2	Ongoing

R Lannon

Trainee Name: Tracy McCrossan Supervisors: Dr Mary Dooher/Dr Rosa Lannon	Placement Type: Health Psychology Placement Dates: 17th January 2019 – 17th January 2021 Date: **Week Commencing 18.05.2020**

Case No.	Demographics (e.g. gender, age, ethnicity)	Referred by	Main Problems	Outline the intervention undertaken, including main treatment modes and any relevant additional information	Formal Evaluation measures used?	Was the work recorded/observed?	No of sessions	Case complete or ongoing?
1(19.05.20)	Male	DSN	Anxiety/Adherence	Assessment	HADS		1	Ongoing
2(20.05.20)	Male	Oncologist	Anxiety	Solution focused therapy	HADS		5	Ongoing
3(20.05.20)	Female	Clinical Psychologist	Hypoglycaemia recognition	CBT	HADS		5	Ongoing
4(21.05.20)	Female	Comm Resp Nurse	Anxiety	CBT	HADS		4	Ongoing



Trainee Name: Tracy McCrossan Supervisors: Dr Mary Dooher/Dr Rosa Lannon	Placement Type: Health Psychology Placement Dates: 17th January 2019 – 17th January 2021 Date: **Week Commencing 25th May 2020**

This week has been a week of Annual leave/preparing my teaching and training content for my case study.

Trainee Name: Tracy McCrossan Supervisors: Dr Mary Dooher/Dr Rosa Lannon	Placement Type: Health Psychology Placement Dates: 17th January 2019 – 17th January 2021 Date: **Week Commencing 1st June 2020**

Case No.	Demographics (e.g. gender, age, ethnicity)	Referred by	Main Problems	Outline the intervention undertaken, including main treatment modes and any relevant additional information	Formal Evaluation measures used?	Was the work recorded/observed?	No of sessions	Case complete or ongoing?
1(01.06.20)	Female	Specialist Nurse	Adjustment	Assessment	HADS		1	Ongoing
2(01.06.20)	Female	Resp Cons	Coping	CBT	HADS		5	Ongoing
3(02.06.20)	Male	DSN	Anxiety/Adherence	Psychoeducation	HADS		2	Ongoing
4(02.06.20)	Female	DSN	Anxiety & low mood	Relaxation hypnotherapy	HADS		2	Ongoing
5(02.06.20)	Female	Comm Resp Nurse	Anxiety	CBT	HADS		4	Ongoing
6(02.06.20)	Female	Comm Resp Nurse	Anxiety	CBT	HADS		5	Ongoing
7(03.06.20)	Female	DSN	Adherence	CBT	HADS		3	Ongoing

8(03.06.20)	Female	Clinical Psychologist	Hypoglycaemia recognition	CBT	HADS		6	Ongoing
9(03.06.20)	Male	Oncologist	Anxiety	Solution focused therapy	HADS		6	Ongoing

Trainee Name: Tracy McCrossan Supervisors: Dr Mary Dooher/Dr Rosa Lannon	Placement Type: Health Psychology Placement Dates: 17th January 2019 – 17th January 2021 Date: **Week Commencing 8th June 2020**

Case No.	Demographics (e.g. gender, age, ethnicity)	Referred by	Main Problems	Outline the intervention undertaken, including main treatment modes and any relevant additional information	Formal Evaluation measures used?	Was the work recorded/observed?	No of sessions	Case complete or ongoing?
1(08.06.20)				Supervision with Dr Lannon				
2(08.06.20)	Male	DSN	Coping with lifestyle change	Assessment	HADS		1	Ongoing
3(08.06.20	Female	DSN	Anxiety needles	Assessment	HADS		1	Ongoing
4(09.06.20)				PMP Meeting OHPCC				
5(10.06.20)	Female	DSN	Coping	Solution Focused Therapy	HADS		3	Ongoing
					HADS			Ongoing

R Lannon

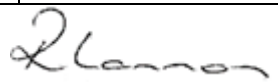
Trainee Name: Tracy McCrossan

Supervisors: Dr Mary Dooher/Dr Rosa Lannon

Placement Type: Health Psychology
Placement Dates: 17th January 2019 – 17th January 2021
Date: **Week Commencing 15th June 2020**

Case No.	Demographics (e.g. gender, age, ethnicity)	Referred by	Main Problems	Outline the intervention undertaken, including main treatment modes and any relevant additional information	Formal Evaluation measures used?	Was the work recorded/observed?	No of sessions	Case complete or ongoing?
1(15.06.20)	Female	Specialist Nurse	Adjustment	Psychoeducation	HADS		2	Ongoing
2(15.06.20)	Male	DSN	Anxiety/Adherence	CBT	HADS		3	Ongoing
3(15.06.20)	Female	Comm Resp Nurse	Anxiety	CBT	HADS		5	Ongoing
4(16.06.20)	Female	Cons Anae	Long term pain	PMP session 6/8			6/8	Ongoing
5(16.06.20)	Female	Cons Anae	Long term pain	PMP session 6/8			6/8	Ongoing
6(16.06.20)	Female	Cons Anae	Long term pain	PMP session 6/8			6/8	Ongoing
7(16.06.20)	Female	Cons Anae	Long term pain	PMP session 6/8			6/8	Ongoing
8(16.06.20)	Female	Cons Anae	Long term pain	PMP session 6/8			6/8	Ongoing
9(16.06.20)	Female	Cons Anae	Long term pain	PMP session 6/8			6/8	Ongoing

10(16.06.20)	Female	Cons Anae	Long term pain	PMP session 6/8			6/8	Ongoing
11(17.06.20)	Female	DSN	Adherence	CBT	HADS		4	Ongoing
12(17.06.20)	Female	Clinical Psychologist	Hypoglycaemia recognition	CBT	HADS		7	Ongoing
13(17.06.20)	Male	Oncologist	Anxiety	Solution focused therapy	HADS		7	Ongoing
14(17.06.20)	Female	Oncologist	Anxiety	CBT	HADS		5	Ongoing
15(17.06.20)	Female	Resp Cons	Coping	CBT	HADS		5	Ongoing
16(18.06.20)				DHP NI AGM				



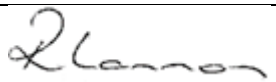
Trainee Name: Tracy McCrossan Supervisors: Dr Mary Dooher/Dr Rosa Lannon	Placement Type: Health Psychology Placement Dates: 17th January 2019 – 17th January 2021 Date: **Week Commencing 22nd June 2020**

Case No.	Demographics (e.g. gender, age, ethnicity)	Referred by	Main Problems	Outline the intervention undertaken, including main treatment modes and any relevant additional information	Formal Evaluation measures used?	Was the work recorded/observed?	No of sessions	Case complete or ongoing?
1(23.06.20)				DHP Conference – Webinar				
2(24.06.20)	Male	Oncology	Acceptance of diagnosis	Assessment	HADS		1	Ongoing
3(24.06.20)	Female	DSN	Coping	Solution Focused Therapy	HADS		4	Ongoing
4(25.06.20)				Health Psychology in PMP – Physio talk ALT				

R Lannon

Trainee Name: Tracy McCrossan Supervisors: Dr Mary Dooher/Dr Rosa Lannon	Placement Type: Health Psychology Placement Dates: 17th January 2019 – 17th January 2021 Date: **Week Commencing 29th June 2020**

Case No.	Demographics (e.g. gender, age, ethnicity)	Referred by	Main Problems	Outline the intervention undertaken, including main treatment modes and any relevant additional information	Formal Evaluation measures used?	Was the work recorded/observed?	No of sessions	Case complete or ongoing?
1(29.06.20)	Female	Specialist Nurse	Adjustment	Psychoeducation	HADS		3	Ongoing
2(29.06.20)	Male	DSN	Anxiety/Adherence	CBT	HADS		4	Ongoing
3(29.06.20)	Female	Comm Resp Nurse	Anxiety	CBT	HADS		6	Ongoing
4(01.07.20)	Female	DSN	Adherence	CBT	HADS		5	Ongoing
5(01.07.20)	Female	Clinical Psychologist	Hypoglycaemia recognition	CBT	HADS		8	Ongoing
6(01.07.20)	Male	Oncologist	Anxiety	Solution focused therapy	HADS		8	Ongoing
7(01.07.20)	Female	Resp Cons	Coping	CBT	HADS		5	Ongoing
8(02.07.20)	Female	DSN	Anxiety & low mood	CBT	HADS		3	Ongoing

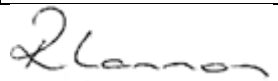
Trainee Name: Tracy McCrossan Supervisors: Dr Mary Dooher/Dr Rosa Lannon	Placement Type: Health Psychology Placement Dates: 17th January 2019 – 17th January 2021 Date: **Week Commencing 6th July 2020**

Case No.	Demographics (e.g. gender, age, ethnicity)	Referred by	Main Problems	Outline the intervention undertaken, including main treatment modes and any relevant additional information	Formal Evaluation measures used?	Was the work recorded/observed?	No of sessions	Case complete or ongoing?
1(06.07.20)				Supervision with Dr Lannon				
2(06.07.20)				Webinar: Health anxiety and COVID 19, Paul Salkovskis				
3(07.07.20)	Female	Cons Anaes	Long term pain	CBT	HADS		3	Ongoing
4(08.07.20)	Male	Oncology	Acceptance of diagnosis	Supportive Counselling	HADS		2	Ongoing
5(08.07.20)	Female	Oncologist	Coping/anxiety	Assessment	HADS		1	Ongoing
					HADS			Ongoing

R Lannon

Trainee Name: Tracy McCrossan Supervisors: Dr Mary Dooher/Dr Rosa Lannon	Placement Type: Health Psychology Placement Dates: 17th January 2019 – 17th January 2021 Date: **Week Commencing 13th July 2020**

Case No.	Demographics (e.g. gender, age, ethnicity)	Referred by	Main Problems	Outline the intervention undertaken, including main treatment modes and any relevant additional information	Formal Evaluation measures used?	Was the work recorded/observed?	No of sessions	Case complete or ongoing?
1(14.07.20)	Female	Specialist Nurse	Adjustment	Psychoeducation	HADS		4	Ongoing
2(14.07.20)	Female	Comm Resp Nurse	Anxiety	CBT	HADS		7	Ongoing
3(14.07.20)	Female	Oncologist	Anxiety	CBT	HADS		6	Ongoing
4(15.07.20)	Female	DSN	Adherence	CBT	HADS		6	Ongoing
5(15.07.20)	Female	Clinical Psychologist	Hypoglycaemia recognition	CBT	HADS		9	Ongoing
6(15.07.20)	Male	Oncologist	Anxiety	Solution focused therapy	HADS		9	Ongoing
7(16.07.20)	Female	Oncologist	Coping/anxiety	Assessment	HADS		2	Ongoing



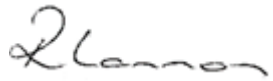
Trainee Name: Tracy McCrossan Supervisors: Dr Mary Dooher/Dr Rosa Lannon	Placement Type: Health Psychology Placement Dates: 17th January 2019 – 17th January 2021 Date: **Week Commencing 20th July 2020**

Case No.	Demographics (e.g. gender, age, ethnicity)	Referred by	Main Problems	Outline the intervention undertaken, including main treatment modes and any relevant additional information	Formal Evaluation measures used?	Was the work recorded/observed?	No of sessions	Case complete or ongoing?
1(21.07.20)	Female	Cons Anaes	Long term pain	PMP 1:1 CBT	HADS		4	Complete
2(22.07.20)	Male	DSN	Anxiety/Adherence	CBT	HADS		5	Ongoing

R Lannon

Trainee Name: Tracy McCrossan Supervisors: Dr Mary Dooher/Dr Rosa Lannon	Placement Type: Health Psychology Placement Dates: 17th January 2019 – 17th January 2021 Date: **Week Commencing 27th July 2020**

Annual Leave Week



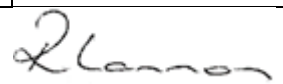
Trainee Name: Tracy McCrossan

Supervisors: Dr Mary Dooher/Dr Rosa Lannon

Placement Type: Health Psychology
Placement Dates: 17th January 2019 – 17th January 2021
Date: **Week Commencing 3rd August 2020**

Case No.	Demographics (e.g. gender, age, ethnicity)	Referred by	Main Problems	Outline the intervention undertaken, including main treatment modes and any relevant additional information	Formal Evaluation measures used?	Was the work recorded/observed?	No of sessions	Case complete or ongoing?
1(03.08.20)	Female	Resp nurse	Coping	Assessment	HADS		1	Ongoing
2(04.08.20)	Female	Specialist Nurse	Adjustment	Psychoeducation	HADS		5	Ongoing
3(04.08.20)	Female	Comm Resp Nurse	Anxiety	CBT	HADS		8	Ongoing
4(04.08.20)	Male	DSN	Anxiety/Adherence	CBT	HADS		6	Ongoing
5(05.08.20)	Female	DSN	Adherence	CBT	HADS		7	Ongoing
6(05.08.20)	Female	Clinical Psychologist	Hypoglycaemia recognition	CBT	HADS		10	Ongoing
7(05.08.20)	Male	Oncologist	Anxiety	Solution focused therapy	HADS		10	Ongoing
8(05.08.20)	Male	Oncology	Coping	Assessment	HADS		1	Ongoing

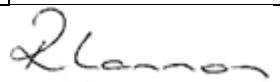
9(05.08.20)	Female	Resp Cons	Coping	CBT	HADS		6	Ongoing



Trainee Name: Tracy McCrossan Supervisors: Dr Mary Dooher/Dr Rosa Lannon	Placement Type: Health Psychology Placement Dates: 17th January 2019 – 17th January 2021 Date: **Week Commencing 10th July 2020)**

Case No.	Demographics (e.g. gender, age, ethnicity)	Referred by	Main Problems	Outline the intervention undertaken, including main treatment modes and any relevant additional information	Formal Evaluation measures used?	Was the work recorded/observed?	No of sessions	Case complete or ongoing?
1(10.08.20)				Supervision with Dr Lannon				
2(10.08.20)	Female	Resp	Anxiety	Assessment	HADS		1	Complete
3(10.08.20)	Female	Specialist Nurse	Lifestyle change	Assessment	HADS		1	Ongoing
4(10.08.20)	Male	Oncology	Coping	Supportive Counselling			2	Ongoing
5(11.08.20)	Female	Oncologist	Coping/anxiety	CBT	HADS		3	Ongoing
6(11.08.20)				Psychology Team Meeting				
7(11.08.20)	Female	Cons Anaes	Long term pain	PMP 1:1	HADS		1	Complete
8(11.08.20)	Male	Cons Anaes	Long term pain	PMP 1:1	HADS		1	Complete
9(11.08.20)	Female	Oncologist	Anxiety	CBT	HADS		7	Ongoing

10(12.08.20)	Male	Oncology	Acceptance of diagnosis	Supportive Counselling	HADS		3	Ongoing
11(12.08.20)	Female	Cons Anaes	Long term pain	PMP 1:1	HADS		1	Complete



Trainee Name: Tracy McCrossan Supervisors: Dr Mary Dooher/Dr Rosa Lannon	Placement Type: Health Psychology Placement Dates: 17th January 2019 – 17th January 2021 Date: **Week Commencing 17th August 2020**

Case No.	Demographics (e.g. gender, age, ethnicity)	Referred by	Main Problems	Outline the intervention undertaken, including main treatment modes and any relevant additional information	Formal Evaluation measures used?	Was the work recorded/observed?	No of sessions	Case complete or ongoing?
1(18.08.20)	Female	Specialist Nurse	Adjustment	Psychoeducation	HADS		6	Ongoing
2(18.08.20)	Male and female group x6	Cons Anaes	Long term pain	PMP review gp	PSEQ4+2 HADS		1	Complete
3(19.08.20)	Male	DSN	Anxiety/Adherence	CBT	HADS		7	Ongoing
4(19.08.20)	Female	DSN	Adherence	CBT	HADS		8	Ongoing
5(19.08.20)	Female	Clinical Psychologist	Hypoglycaemia recognition	CBT	HADS		11	Ongoing
6(19.08.20)	Male	Oncologist	Anxiety	Solution focused therapy	HADS		11	Ongoing
7(19.08.20)	Female	Resp Cons	Coping	CBT	HADS		7	Ongoing
8(20.08.20)	Female	Resp Cons	Coping	CBT	HADS		7	Complete

R Lannon

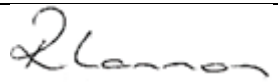
Trainee Name: Tracy McCrossan Supervisors: Dr Mary Dooher/Dr Rosa Lannon	Placement Type: Health Psychology Placement Dates: 17th January 2019 – 17th January 2021 Date: **Week Commencing 24th August 2020**

Case No.	Demographics (e.g. gender, age, ethnicity)	Referred by	Main Problems	Outline the intervention undertaken, including main treatment modes and any relevant additional information	Formal Evaluation measures used?	Was the work recorded/observed?	No of sessions	Case complete or ongoing?
1(24.08.20)	Female	DSN	Anxiety & low mood	CBT	HADS		4	Ongoing
2(25.08.20)				Preparation for teaching and training				Ongoing
3(26.08.20)				Preparation for teaching and training				Ongoing

R Lannon

Trainee Name: Tracy McCrossan Supervisors: Dr Mary Dooher/Dr Rosa Lannon	Placement Type: Health Psychology Placement Dates: 17th January 2019 – 17th January 2021 Date: **Week Commencing 31st August 2020**

Case No.	Demographics (e.g. gender, age, ethnicity)	Referred by	Main Problems	Outline the intervention undertaken, including main treatment modes and any relevant additional information	Formal Evaluation measures used?	Was the work recorded/observed?	No of sessions	Case complete or ongoing?
1(02.09.20)	Female	Oncologist	Coping/anxiety	CBT	HADS		4	Ongoing
2(02.09.20)	Male	Renal	Adherence	Assessment	HADS		1	Complete
3(03.09.20)				Psychoneuroimmunology Teaching				



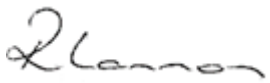
Trainee Name: Tracy McCrossan Supervisors: Dr Mary Dooher/Dr Rosa Lannon	Placement Type: Health Psychology Placement Dates: 17th January 2019 – 17th January 2021 Date: **Week Commencing 7th September 2020**

Case No.	Demographics (e.g. gender, age, ethnicity)	Referred by	Main Problems	Outline the intervention undertaken, including main treatment modes and any relevant additional information	Formal Evaluation measures used?	Was the work recorded/observed?	No of sessions	Case complete or ongoing?
1(08.09.20)	Male	Cons Anaes	Long term pain	Assessment PMP	HADS		1	Ongoing
2(08.09.20)	Female	Cons Anaes	Long term Pain	Assessment PMP	HADS		1	Ongoing
3(08.09.20)	Female	Cons Anaes	Long Term pain	Assessment PMP	HADS		1	Ongoing
4(09.09.20)	Female	Clinical Psychologist	Hypoglycaemia recognition	CBT	HADS		11	Ongoing
5(09.09.20)	Male	Oncology	Acceptance of diagnosis	Supportive Counselling	HADS		4	Ongoing

6(10.09.20)	Female	Cons Cardiologist	Anxiety	Assessment with interpreter	HADS		1	Ongoing
7(10.09.20)	Male	Oncologist	Anxiety	Solution focused therapy	HADS		12	Ongoing
8(10.09.20)				Psychoneuroimmunology 2				

Trainee Name: Tracy McCrossan Supervisors: Dr Mary Dooher/Dr Rosa Lannon	Placement Type: Health Psychology Placement Dates: 17th January 2019 – 17th January 2021 Date: **Week Commencing 14th Sept 2020**

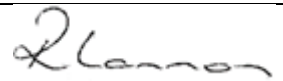
Case No.	Demographics (e.g. gender, age, ethnicity)	Referred by	Main Problems	Outline the intervention undertaken, including main treatment modes and any relevant additional information	Formal Evaluation measures used?	Was the work recorded/observed?	No of sessions	Case complete or ongoing?
1(15.09.20)				Webinar: 7 reasons you'll pass your viva				
2(15.09.20)	Female	Specialist Nurse	Adjustment	Psychoeducation	HADS		7	Ongoing
3(16.09.20)	Female	Oncologist	Coping/anxiety	CBT	HADS		5	Ongoing
4(16.09.20)	Male	DSN	Anxiety/Adherence	CBT	HADS		8	Ongoing
5(16.09.20)	Female	DSN	Anxiety & low mood	CBT	HADS		5	Ongoing
5(17.08.20)				Psychoneuroimmunology 3				
6(18.08.20)	Male and female group	Cons Anaes	Long term pain	PMP Group Programme Virtual	PSEQ4+2 HADS		1 of 10	Ongoing



Trainee Name: Tracy McCrossan Supervisors: Dr Mary Dooher/Dr Rosa Lannon	Placement Type: Health Psychology Placement Dates: 17th January 2019 – 17th January 2021 Date: **Week Commencing 21st September 2020**

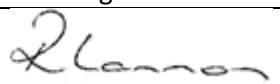
Case No.	Demographics (e.g. gender, age, ethnicity)	Referred by	Main Problems	Outline the intervention undertaken, including main treatment modes and any relevant additional information	Formal Evaluation measures used?	Was the work recorded/observed?	No of sessions	Case complete or ongoing?
1(21.09.20)				Webinar: Functional neurological disorders, suggestion, dissociation, belief and pain relief.				
2(21.09.20)				IPC training via pexip				
3(22.09.20)	Female	Cons Anaes	Long term pain	Assessment PMP	HADS		1	Ongoing
4(22.09.20)	Female	Cons Anaes	Long term pain	Assessment PMP	HADS		1	Ongoing
5(23.09.20)	Female	DSN	Coping	Assessment	HADS		1	Ongoing
6(23.09.20)	Female	Clinical Psychologist	Hypoglycaemia recognition	CBT	HADS		12	Complete
7(23.09.20)	Female	Oncologist	Anxiety	CBT	HADS		8	Complete
8(24.09.20)				Psychoneuroimmunology 3+4 teaching				

9(24.09.20)				Psychology Team Meeting				



Trainee Name: Tracy McCrossan Supervisors: Dr Mary Dooher/Dr Rosa Lannon	Placement Type: Health Psychology Placement Dates: 17th January 2019 – 17th January 2021 Date: **Week Commencing 28th September 2020**

Case No.	Demographics (e.g. gender, age, ethnicity)	Referred by	Main Problems	Outline the intervention undertaken, including main treatment modes and any relevant additional information	Formal Evaluation measures used?	Was the work recorded/observed?	No of sessions	Case complete or ongoing?
1(28.09.20)				Supervision with Dr Lannon				
2(29.09.20)				PMP Team Meeting				
3(29.09.20)	Female	Specialist Nurse	Adjustment	CBT	HADS		8	Complete
3(29.09.20)	Female	Resp Cons	Coping	CBT	HADS		8	Complete
4(30.09.20)	Female	Oncologist	Coping/anxiety	CBT	HADS		6	Ongoing
5(30.09.20)	Male	DSN	Anxiety/Adherence	CBT	HADS		9	Ongoing
6(30.09.20)	Female	DSN	Anxiety & low mood	CBT	HADS		6	Ongoing
7(30.09.20)	Male	Oncology	Acceptance of diagnosis	Supportive Counselling	HADS		5	Ongoing
8(01.10.20)				Psychoneuroimmunology 5 teaching				

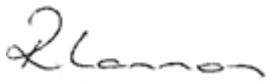


Trainee Name: Tracy McCrossan Supervisors: Dr Mary Dooher/Dr Rosa Lannon	Placement Type: Health Psychology Placement Dates: 17th January 2019 – 17th January 2021 Date: **Week Commencing 5th October 2020**

Case No.	Demographics (e.g. gender, age, ethnicity)	Referred by	Main Problems	Outline the intervention undertaken, including main treatment modes and any relevant additional information	Formal Evaluation measures used?	Was the work recorded/observed?	No of sessions	Case complete or ongoing?
1(06.10.20)				PMP meeting				
2(07.10.20)	Male	Oncology	Acceptance	Assessment	HADS		1	Ongoing
3(08.10.20)				Supervision with Rachel and Helen				

Trainee Name: Tracy McCrossan Supervisors: Dr Mary Dooher/Dr Rosa Lannon	Placement Type: Health Psychology Placement Dates: 17th January 2019 – 17th January 2021 Date: **Week Commencing 12th Oct 2020**

Case No.	Demographics (e.g. gender, age, ethnicity)	Referred by	Main Problems	Outline the intervention undertaken, including main treatment modes and any relevant additional information	Formal Evaluation measures used?	Was the work recorded/observed?	No of sessions	Case complete or ongoing?
1(13.10.20)				Telephone call DSN re patient				
2(13.10.20)	Male	Cons Anaes	Long term pain	PMP Assessment	PSEQ4+2 HADS		1	Ongoing
3(14.10.20)	Female	DSN	Anxiety & low mood	CBT	HADS		7	Ongoing
4(15.10.20)	Female	DSN	Coping	Assessment	HADS		1	Ongoing
5(15.10.20)	Male	Oncology	Acceptance of diagnosis	Supportive Counselling	HADS		5	Ongoing



Trainee Name: Tracy McCrossan Supervisors: Dr Mary Dooher/Dr Rosa Lannon	Placement Type: Health Psychology Placement Dates: 17th January 2019 – 17th January 2021 Date: **Week Commencing 19th October 2020**

Case No.	Demographics (e.g. gender, age, ethnicity)	Referred by	Main Problems	Outline the intervention undertaken, including main treatment modes and any relevant additional information	Formal Evaluation measures used?	Was the work recorded/observed?	No of sessions	Case complete or ongoing?
1(19.10.20)				Telephone call with DSN research				
2(19.10.20)	Male	Resp Cons	Coping/panic	Assessment	HADS		1	Ongoing
3(19.10.20)	Male	Oncology	Acceptance of diagnosis	Supportive Counselling	HADS		6	Ongoing
4(19.10.20)	Female	Cons Cardiologist	Anxiety	Psychoeducation	HADS		2	Ongoing
5(20.10.20)				PMP Planning/revise talks				
6(21.10.20)	Male	Oncology	Acceptance	Assessment	HADS		2	Complete
7(21.10.20)	Male	DSN	Anxiety/Adherence	CBT	HADS		10	Complete
8(21.10.20)	Male	Oncology	Acceptance of diagnosis	Supportive Counselling	HADS		6	Complete
9(23.10.20)				Telephone call DSN research				

R Lannon

Trainee Name: Tracy McCrossan Supervisors: Dr Mary Dooher/Dr Rosa Lannon	Placement Type: Health Psychology Placement Dates: 17th January 2019 – 17th January 2021 Date: **Week Commencing 26th October 2020**

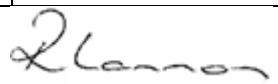
Case No.	Demographics (e.g. gender, age, ethnicity)	Referred by	Main Problems	Outline the intervention undertaken, including main treatment modes and any relevant additional information	Formal Evaluation measures used?	Was the work recorded/observed?	No of sessions	Case complete or ongoing?
1(26.10.20)				Supervision with Dr Lannon				
2(26.10.20)	Male	Oncology	Acceptance of diagnosis	Supportive Counselling	HADS		7	Ongoing
3(26.10.20)	Female	Cons Cardiologist	Anxiety	Psychoeducation	HADS		3	Ongoing
4(27.10.20)	Male	Cons Anaes	Long term pain	Assessment PMP	PSEQ4+2 HADS		1	Ongoing
5(27.10.20)	Female	Cons Anaes	Long term Pain	Assessment PMP	PSEQ4+2 HADS		1	Ongoing
6(27.10.20)	Female	Oncologist	Coping/anxiety	CBT	HADS		7	Ongoing
7(28.10.20)				Telephone call with dietician research				
8(30.10.20)				Telephone call with DSN research				

RLannon

Trainee Name: Tracy McCrossan Supervisors: Dr Mary Dooher/Dr Rosa Lannon	Placement Type: Health Psychology Placement Dates: 17th January 2019 – 17th January 2021 Date: **Week Commencing 2nd November 2020**

Case No.	Demographics (e.g. gender, age, ethnicity)	Referred by	Main Problems	Outline the intervention undertaken, including main treatment modes and any relevant additional information	Formal Evaluation measures used?	Was the work recorded/observed?	No of sessions	Case complete or ongoing?
1(02.11.20)	Male	Resp Cons	Coping/panic	psychoeducation	HADS		2	Ongoing
2(02.11.20)	Female	Renal Cons	Adherence/coping	Assessment	HADS		1	Ongoing
3(03.11.20)				DHP NI Meeting				
4(03.11.20)	Female	DSN	Coping	Assessment	HADS		1	Complete
5(03.11.20)	Female	DSN	Anxiety/Panic	Assessment	HADS		1	Complete
6(04.11.20)	Female	Resp Cons	Coping	Assessment	HADS		1	Ongoing
7(04.11.20)	Female	Gastro Cons	Coping	Assessment	HADS		1	Ongoing
8(04.11.20)				Webinar: PTSD following critical illness and ICU admission				
9(04.11.20)	Female	DSN	Anxiety & low mood	CBT	HADS		8	Ongoing
10(05.11.20)	Male	Oncologist	Coping/Anxiety	Assessment	HADS		1	Complete

11(06.11.20)	Male and female mixed	Cons anaes	Long term pain	PMP group – values talk			6/10	



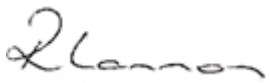
Trainee Name: Tracy McCrossan Supervisors: Dr Mary Dooher/Dr Rosa Lannon	Placement Type: Health Psychology Placement Dates: 17th January 2019 – 17th January 2021 Date: **Week Commencing 9th November 2020**

Case No.	Demographics (e.g. gender, age, ethnicity)	Referred by	Main Problems	Outline the intervention undertaken, including main treatment modes and any relevant additional information	Formal Evaluation measures used?	Was the work recorded/observed?	No of sessions	Case complete or ongoing?
1(09.11.20)	Male	Renal Cons	Coping	Assessment	HADS		1	Ongoing
2(09.11.20)	Female	Resp Cons	Coping/anxiety	Assessment	HADS		1	Ongoing
3(09.11.20)	Male	Oncology	Acceptance of diagnosis	Supportive Counselling	HADS		8	Ongoing
4(10.11.20)	Female	Oncologist	Coping/anxiety	CBT	HADS		8	Ongoing
5(11.11.20)	Female	Cons Cardiologist	Anxiety	Psychoeducation	HADS		4	Ongoing

R Lannon

Trainee Name: Tracy McCrossan Supervisors: Dr Mary Dooher/Dr Rosa Lannon	Placement Type: Health Psychology Placement Dates: 17th January 2019 – 17th January 2021 Date: **Week Commencing 16th November 2020**

Case No.	Demographics (e.g. gender, age, ethnicity)	Referred by	Main Problems	Outline the intervention undertaken, including main treatment modes and any relevant additional information	Formal Evaluation measures used?	Was the work recorded/observed?	No of sessions	Case complete or ongoing?
1(16.11.20)	Male	Resp Cons	Coping/panic	CBT	HADS		3	Ongoing
2(17.11.20)	Female	Renal Cons	Adherence/coping	Relaxation	HADS		2	Ongoing
3(18.11.20)	Female	DSN	Anxiety & low mood	CBT	HADS		9	Ongoing



Trainee Name: Tracy McCrossan Supervisors: Dr Mary Dooher/Dr Rosa Lannon	Placement Type: Health Psychology Placement Dates: 17th January 2019 – 17th January 2021 Date: **Week Commencing 23rd November 2020**

Case No.	Demographics (e.g. gender, age, ethnicity)	Referred by	Main Problems	Outline the intervention undertaken, including main treatment modes and any relevant additional information	Formal Evaluation measures used?	Was the work recorded/observed?	No of sessions	Case complete or ongoing?
1(23.11.20)	Female	Resp Cons	Coping/anxiety	Assessment	HADS		2	Ongoing
2(23.11.20)	Male	Oncology	Acceptance of diagnosis	Supportive Counselling	HADS		9	Ongoing
3(24.11.20)	Female	Cons Anaes	Long term pain	PMP Assess	PSEQ4+2 HADS		1	Ongoing
4(24.11.20)	Female	Cons Anaes	Long term pain	PMP Assess	PSEQ4+2 HADS		1	Ongoing
5(25.11.20)				ACT for chronic pain webinar				
6(25.11.20)				Webinar: Exploring the use of infographics in health psychology	HADS			
7(26.11.20)				Annual Review Dr Helen Poole				

Trainee Name: Tracy McCrossan Supervisors: Dr Mary Dooher/Dr Rosa Lannon	Placement Type: Health Psychology Placement Dates: 17th January 2019 – 17th January 2021 Date: **Week Commencing 30th Nov 2020**

Case No.	Demographics (e.g. gender, age, ethnicity)	Referred by	Main Problems	Outline the intervention undertaken, including main treatment modes and any relevant additional information	Formal Evaluation measures used?	Was the work recorded/observed?	No of sessions	Case complete or ongoing?
1(30.11.20)				Supervision with dr Lannon				
2(30.11.20)	Male	Resp Cons	Coping/panic	CBT	HADS		4	Ongoing
3(01.12.20)	Male	Cons Anaes	Long term pain	PMP Assess	PSEQ4+2 HADS		1	Ongoing
4(01.12.20)	Female	Cons Anaes	Long term pain	PMP Assess	PSEQ4+2 HADS		1	Ongoing
5(01.12.20)	Female	Cons Anaes	Long term pain	PMP Assess	PSEQ4+2 HADS		1	Ongoing
6(01.12.20)	Female	Cons Anaes	Long term pain	PMP Assess	PSEQ4+2 HADS		1	Ongoing
7(01.12.20)	Female	Renal Cons	Adherence/coping	Relaxation	HADS		3	
8(02.12.20)	Female	DSN	Coping/Anxiety	Assessment	HADS		1	Ongoing
9(02.12.20)	Female	Resp Cons	Low mood/coping	Assessment	HADS		1	Complete
10(02.12.20)	Male	DSN	Adherence	Assessment	HADS		1	Ongoing

11(02.12.20)	Female	Resp Cons	Coping	CBT	HADS		2	Ongoing
12(03.12.20)	Male	Renal Cons	Coping	Supportive Counselling	HADS		2	Ongoing
13(03.12.20)	Female	Oncologist	Coping/anxiety	CBT	HADS		9	Ongoing
14(03.12.20)	Male	Oncology	Acceptance of diagnosis	Supportive Counselling	HADS		10	Ongoing

Trainee Name: Tracy McCrossan Supervisors: Dr Mary Dooher/Dr Rosa Lannon	Placement Type: Health Psychology Placement Dates: 17th January 2019 – 17th January 2021 Date: **Week Commencing 7th Dec 2020**

Case No.	Demographics (e.g. gender, age, ethnicity)	Referred by	Main Problems	Outline the intervention undertaken, including main treatment modes and any relevant additional information	Formal Evaluation measures used?	Was the work recorded/observed?	No of sessions	Case complete or ongoing?
1(7.12.20)	Female	Resp Cons	Coping/anxiety	ACT	HADS		3	Ongoing
2(08.12.20)	Male	Cons Anaes	Long term pain	PMP Assess	PSEQ4+2 HADS		1	Ongoing
3(08.12.20)	Female	Cons Anaes	Long term pain	PMP Assess	PSEQ4+2 HADS		1	Ongoing
4(9.12.20)	Female	DSN	Coping/Anxiety	Assessment	HADS		2	Ongoing
5(9.12.20)	Female	DSN	Anxiety & low mood	CBT	HADS		10	Ongoing
					HADS			Ongoing

Trainee Name: Tracy McCrossan Supervisors: Dr Mary Dooher/Dr Rosa Lannon	Placement Type: Health Psychology Placement Dates: 17th January 2019 – 17th January 2021 Date: **Week Commencing 14th Dec 2020**

Case No.	Demographics (e.g. gender, age, ethnicity)	Referred by	Main Problems	Outline the intervention undertaken, including main treatment modes and any relevant additional information	Formal Evaluation measures used?	Was the work recorded/observed?	No of sessions	Case complete or ongoing?
1(14.12.20)	Male	Resp Cons	Coping/panic	CBT	HADS		5	Ongoing
2(14.12.20)	Male	Oncology	Low mood	Assessment	HADS		1	Ongoing
3(14.12.20)	Female	Oncology	Coping	Assessment	HADS		1	Complete
4(15.12.20)	Male	Oncology	Acceptance of diagnosis	Supportive Counselling	HADS		11	Ongoing
5(15.12.20)	Female	Renal Cons	Adherence/coping	Relaxation	HADS		4	Ongoing
6(16.12.20)	Male	DSN	Adherence	Assessment	HADS		2	Ongoing
7(16.12.20)	Female	Resp Cons	Coping	CBT	HADS		3	Ongoing
8(17.12.20)	Male	Renal Cons	Coping	Supportive Counselling	HADS		3	Ongoing
9(17.12.20)	Female	Oncologist	Coping/anxiety	CBT	HADS		10	Ongoing

R Lannon

Trainee Name: Tracy McCrossan Supervisors: Dr Mary Dooher/Dr Rosa Lannon	Placement Type: Health Psychology Placement Dates: 17th January 2019 – 17th January 2021 Date: **Week Commencing 21st Dec 2020**

Case No.	Demographics (e.g. gender, age, ethnicity)	Referred by	Main Problems	Outline the intervention undertaken, including main treatment modes and any relevant additional information	Formal Evaluation measures used?	Was the work recorded/observed?	No of sessions	Case complete or ongoing?
1(21.12.20)	Female	Oncologist	Coping/anxiety	CBT	HADS		11	Ongoing
2(21.12.20)	Male	Renal Cons	Coping	Supportive Counselling	HADS		4	Ongoing
3(22.12.20)	Female	Renal Cons	Adherence/coping	CBT	HADS		5	Ongoing
4(22.12.20)	Female	Resp Cons	Coping	CBT	HADS		4	Ongoing
5(23.12.20)				Meeting with Dr helen Poole				
					HADS			Ongoing

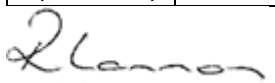
R Lannon

Trainee Name: Tracy McCrossan Supervisors: Dr Mary Dooher/Dr Rosa Lannon	Placement Type: Health Psychology Placement Dates: 17th January 2019 – 17th January 2021 Date: **Week Commencing 28th Dec 2020**

Annual Leave all week

Trainee Name: Tracy McCrossan Supervisors: Dr Mary Dooher/Dr Rosa Lannon	Placement Type: Health Psychology Placement Dates: 17th January 2019 – 17th January 2021 Date: **Week Commencing 4th Jan 2021**

Case No.	Demographics (e.g. gender, age, ethnicity)	Referred by	Main Problems	Outline the intervention undertaken, including main treatment modes and any relevant additional information	Formal Evaluation measures used?	Was the work recorded/observed?	No of sessions	Case complete or ongoing?
1(04.01.21)	Female	Oncologist	Coping/anxiety	CBT	HADS		12	Ongoing
2(04.01.21)	Male	Renal Cons	Coping	Supportive Counselling	HADS		4	Ongoing
3(06.01.21)	Female	Renal Cons	Adherence/coping	CBT	HADS		6	Ongoing
4(06.01.21)	Female	Resp Cons	Coping	CBT	HADS		5	Ongoing



Trainee Name: Tracy McCrossan Supervisors: Dr Mary Dooher/Dr Rosa Lannon	Placement Type: Health Psychology Placement Dates: 17th January 2019 – 17th January 2021 Date: **Week Commencing 11th Jan 2021**

Case No.	Demographics (e.g. gender, age, ethnicity)	Referred by	Main Problems	Outline the intervention undertaken, including main treatment modes and any relevant additional information	Formal Evaluation measures used?	Was the work recorded/observed?	No of sessions	Case complete or ongoing?
1(11.01.21)	Male	Renal Cons	Coping	Supportive Counselling	HADS		5	Complete
2(11.01.21)	Female	Resp Cons	Coping	CBT	HADS		5	Ongoing
3(11.01.21)	Female	DSN	Adherence	Solution Focused Therapy + CBT	HADS		6	Ongoing
4(12.01.21)	Male and female group x 6	Cons anaes	Long term pain	PMP group	HADS		1/10	Ongoing